Physician Payment
Review Commission

March 1, 1987

Medicare Physician Payment: An Agenda for Reform

Annual Report to Congress

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MEDICARE PHYSICIAN PAYMENT: AN AGENDA FOR REFORM

Physician Payment Review Commission

March 1, 1987

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PREFACE

The Physician Payment Review Commission was created by Congress in the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) to review current methods for paying physicians under the Medicare program and to make recommendations for change. The Commission held its first meeting in November 1986.

The Commission is required to report its recommendations to Congress by March 1 of each year. This first report to Congress reflects the Commission's work during its first four months. The rapid progress that it made in charting the course for policy reform during this short period is due in large measure both to the hard work of the Commissioners and the Commission staff and to the many people and organizations who willingly shared their expertise and perspectives.

Staff from the Health Care Financing Administration and other agencies of the Department of Health and Human Services, the Congress, the Office of Technology Assessment, the Congressional Budget Office, and the Congressional Research Service made very useful comments on earlier drafts of the report. In addition, independent experts in physician payment and individuals from organizations and associations representing Medicare beneficiaries, health professionals and the insurance industry provided helpful suggestions. The Commission's work also was facilitated by the major reports on physician payment reform that were published in 1986 by the Office of Technology Assessment and the Congressional Budget Office.

Philip R. Lee, M.D.
Chairman

March 1, 1987

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EXECUTIVE SUMMARY

In 1986, Congress created the Physician Payment Review Commission (PPRC) to provide advice on reforms in the methods used to pay physicians for services to Medicare beneficiaries. The PPRC began its work in November of that year. The Commission is comprised of thirteen members who represent a broad range of experience and perspectives on issues concerning physician payment.

The Commission plays four roles. First, it serves as a source of independent expert advice to Congress and to the Secretary of Health and Human Services. Second, PPRC provides opportunities for beneficiaries, physicians, and other interested parties to have their views considered in policy deliberations on physician payment issues. Third, the Commission conducts objective analyses to provide a basis for policy decisions to alter Medicare's method of paying physicians. Fourth, it performs design work necessary to implement major changes in physician payment.

The PPRC is mandated to make recommendations to the Congress by March 1 of each year "...regarding adjustments to the reasonable charge levels for physicians' services...and changes in the methodology for determining the rates of payment, and for making payment for physicians' services..." under Part B of the Medicare program. The mandate requires PPRC to address specific issues related to physician payment, including differences in payments based on specialty or geographic location, the reasonableness of charges for various services, and acceptance of assignment by physicians.

When Medicare was adopted in 1965, policymakers specified in broad terms how the program should pay physicians. Payment was to be based on reasonable charges. These were defined as a physician's actual charges, as long as those charges did not exceed the physician's customary charges in the previous year or the prevailing charges of other doctors in the locality. These guidelines provided the basis for CPR, the "customary, prevailing and reasonable" method of Medicare physician payment.

The CPR payment methodology has come under increasing criticism because of the poor incentives it provides for cost-effective service delivery. In particular, it has been criticized for:

- encouraging increases in physicians' charges and the volume of services;
- creating patterns of allowed charges that embody inappropriate incentives for the use of medical services as well as for physicians' decisions on where to locate and what to specialize in; and

- being administratively complex and difficult for both physicians and beneficiaries to understand.

GOALS FOR PHYSICIAN PAYMENT POLICY

The Medicare program was designed to provide the elderly with financial protection from the costs of medical care and, in the process, to increase access to services of high quality. In assessing options for reform that will support efforts by Congress to protect and improve the achievements of the Medicare program, the Commission is guided by the following goals:

Access to Care. Reforms in the methods for paying for physicians' services must ensure that all beneficiaries have access to medical care. In the short run, access reflects physicians' willingness to care for Medicare patients and patients' abilities to afford the care. In the long run, access also depends on the supply of physicians and their choices of location and specialty. For those beneficiaries electing to continue to receive care through the fee-for-service system, free choice of physician must be maintained.

Quality of Care. Reforms in the methods or levels of payment should maintain or improve the quality of care provided to Medicare beneficiaries. Beneficiaries should receive high quality care provided through efficient medical practice.

Financial Protection for Beneficiaries. Reforms in payment to physicians should maintain financial protection for beneficiaries. While some patient financial responsibility for the cost of care may be appropriate, levels of responsibility should not be so high that they prevent beneficiaries from gaining access to care or impose significant economic hardship. The Commission is particularly concerned with limiting the responsibility of beneficiaries for charges in excess of what Medicare allows.

Equity among Physicians. Reforms in the levels or methods of payment should increase equity among physicians, so that similar payments are made for similar services among similarly qualified physicians. Differences in payments for different services should broadly reflect relative costs, market conditions, and other appropriate factors.

Reduction in the Growth of SMI Outlays. Reforms in physician payment should slow the growth in federal outlays for Supplementary Medical Insurance. The growing burden on taxpayers, who underwrite 75 percent of program costs through general revenues, and beneficiaries, who underwrite 25 percent of the cost through premiums, is becoming an increasingly serious problem. One way to address the fiscal problem without shifting it to others is to encourage increased efficiency in the practice of medicine. This can be achieved through more appropriate payment incentives to physicians, improved review of how services are

used, expanded research, and better education of physicians and beneficiaries. In evaluating policy changes that reduce outlays in Part B of Medicare, the potential for offsetting increases in outlays for Part A of Medicare must be considered.

Understandability. Reforms should make the method of paying physicians easier for beneficiaries, physicians, and the general public to understand. Physicians should know what charges Medicare will allow, and beneficiaries should be informed by physicians what they are expected to pay. Where feasible, this information should be provided before service is delivered.

Orderly Change. Reforms in the method of payment should be orderly and coherent. Short-term change should be consistent with long-term policy goals. The feasibility of administering the specific changes must be taken into account, especially in setting schedules for their implementation. As major reforms are implemented, monitoring their effects should be given high priority because these effects are uncertain and midcourse corrections may be required.

Pluralism. Reforms in payment methods should accommodate the various ways health services are organized. Both fee-for-service methods and capitation should play a role in the delivery of medical care in the United States.

In its study of Medicare's methods of paying physicians, the Commission has come to three conclusions that will guide it in making specific recommendations. First, tradeoffs among the goals outlined above are inevitable. While certain goals can be achieved simultaneously--for example, more efficient medical practice may increase quality of care--conflicts among the goals may well arise. When tradeoffs must be made, access to care and financial protection for beneficiaries should not be sacrificed.

Second, current differences in charges for physician services provide distorted signals to physicians and cause serious inequities among physicians. These distortions and inequities may affect physicians' decisions concerning what services to provide, what specialty to train for, and where to locate a medical practice. These problems result from a market in which consumers have difficulty in shopping for prices and where uneven insurance coverage obscures the signals consumers are able to deliver. Careful attempts to develop relative value scales that take into account factors in addition to existing patterns of charges may lead to relative payments that will provide more appropriate signals to physicians.

Third, since medical care is both an art and a science, physicians' decisions will continue to be pivotal in the delivery of effective care. One central challenge to policy is to find a way to incorporate society's concerns about limited resources into physicians' decisionmaking while

maintaining the physician's freedom and responsibility to exercise clinical judgment on behalf of the patient.

RECOMMENDATIONS AND WORKPLAN

There are four general alternatives for reforming the way physicians are paid under the Medicare program: refining the current payment system, making payments according to a fee schedule, creating a system of all-inclusive fees for defined packages of services, and increasing the use of capitation payments. In this report, the Commission focuses on the first two alternatives. The other alternatives will be taken up in subsequent reports.

The Commission has charted a course to follow for the long term and recommended immediate improvements in the current payment system that are consistent with long-term objectives. The first recommendation describes the Commission's plans to develop a fee schedule. Other PPRC recommendations apply primarily to the current payment system, but they also will be relevant to the adoption of a fee schedule.

A Fee Schedule

The Commission endorses the concept of a fee schedule for Medicare. Under such an arrangement, the pattern of payments for services would differ from that under the current system by type of procedure, practice setting, geographic location, and perhaps by specialty. Adoption of a fee schedule requires major decisions on design. For example, how should relative values be determined? How are payments to vary by practice setting and geographic location? How should the payments be updated over time? And, is a different policy concerning assignment needed? The Commission plans to examine these and other issues during the next year.

The Commission does not consider its endorsement of a fee schedule for Medicare as precluding future recommendation of other methods for paying for physicians' services, either in addition to or in place of fee for service. It plans to study such alternative ways of paying for physicians' services as all-inclusive fees and capitation.

Geographic Variation

The Commission has serious concerns with geographic variations in payment and recommends that changes be made soon. Current patterns of payment may be contributing to access problems for beneficiaries in some rural areas and in some low-income districts of metropolitan areas as well. Secondarily, the patterns are unfair to the physicians practicing in these areas.

The Commission recommends a special payment increment for primary care services provided in designated underserved areas. The payment would not affect coinsurance amounts. It would be financed by a small reduction in the update factor for the Medicare Economic Index.

The PPRC expects to consider more comprehensive approaches to geographic variation in payment. It plans a substantial amount of analysis over the next year to gain a better understanding of both current patterns of geographic variation and the likely impact of various options for reform.

Inherent Reasonableness

The Commission endorses the use of recently enacted provisions on "inherent reasonableness" to make interim changes in relative payments. When applied carefully through an open process that takes into account the views of interested parties, inherent reasonableness has the potential of redressing distortions in relative payments that have arisen under current payment methods. Such changes may achieve short-term budget savings in ways that are more consistent with long-term policy directions than are across-the-board reductions in payment rates.

Application of inherent reasonableness will increase payments for some services and reduce them for others. The increases that do occur need not preclude a net decrease in Medicare outlays for physicians' services.

The Commission has concerns, however, that the procedural requirements of the legislation defining inherent reasonableness, in conjunction with limitations of data and research funds, will limit the extent to which the process authorized can be used to change payment patterns. To augment the limited data available, the Commission plans to test a consensus process for developing recommendations for changes in payment.

This process will not be available in time to assist the Secretary of HHS or the Congress with decisions for the Fiscal Year 1988 budget cycle. Nevertheless, if asked for assistance with decisions on inherent reasonableness so that objectives for FY88 might be met, PPRC will attempt to provide guidance through more limited mechanisms. These include a review of the implications of various relative value scales that have been developed in the United States and abroad.

Assignment and the Participating Physician Program

The PPRC notes the potential of the numerous provisions in the Omnibus Budget Reconciliation Act of 1986 to increase assignment through improvements in the information provided to beneficiaries and changes in incentives for physicians. In view of the recent enactment and pending implementation of these policy changes, the Commission's recommendations focus on the need for careful monitoring and evaluation. In addition, it plans to devote continuing attention to additional ways to ease claims

processing for participating physicians and to increase beneficiaries' familiarity with the participating physician program.

The Medicare Economic Index

Over more than a decade, the Medicare Economic Index (MEI) has limited rates of increase in allowable charges. Although the weights have been updated periodically, the index continues to be applied to 1973 prevailing charges. The Commission plans to examine a number of methods for rebasing the MEI. Rebasing is likely to have a substantial effect on relative payments, so before recommending a specific method, PPRC wants to ensure that changes are generally consistent with the types of fee schedules it contemplates and that those changes would not increase program expenditures.

Program Administration

The Commission considers improvement in program administration to be a key element in the reform of Medicare physician payment. Its recommendations cover four areas: funding, flexibility for carriers, standards for carriers, and research on effective carrier activities.

Adequate funding of Medicare administration is critical to protecting beneficiaries and containing benefit costs. Funding levels should reflect the complexity and scope of program requirements. The funding provided to carriers can go further if the carriers are given greater flexibility to allocate funds to their most productive uses.

At the same time, strong standards for carriers' processing of claims in areas such as prompt payment, accuracy, and service to beneficiaries and physicians should be a priority. Persistently poor performers should be replaced.

The effectiveness of various carrier activities has not been studied adequately. The Commission recommends that HCFA expand research to identify cost-effective utilization review and other benefit cost management techniques used by carriers, Peer Review Organizations, and private payers.

Coding

Lack of refinement and standardization in the coding of procedures has been a serious problem in administering physician payments and could be a limiting factor in implementing a fee schedule. The PPRC recommends that the definition of codes for medical and surgical services, including those representing services covered by global fees for surgery, be refined and standardized. The Commission will convene an expert panel to make recommendations for change.

Assistance at Surgery

Medicare typically pays for assistance at surgery by physicians and others. Serious doubts have been raised about how frequently physicians are needed as assistants and whether payment by Medicare is appropriate. The PPRC recommends that Medicare limits on payment for assistance at surgery be supplemented by additional definitions and guidelines. An assistant at surgery should be defined as an individual who has the necessary qualifications to participate in the particular type of operation and who actively assists the surgeon in performing the surgical procedure. Medicare also must specify practical guidelines for claims review by carriers. The PPRC plans to test the use of panels of surgeons and others to develop practical guidelines for carriers.

Data

Timely, relevant and accurate data are crucial to the consideration of reforms in Medicare physician payment methods as well as to program management, quality assessment, and utilization review. The Commission notes the recent progress in improving data systems by the Health Care Financing Administration and encourages continued efforts in this area, particularly those mandated by the Congress in recent legislation. The Commission will assist HCFA and other federal agencies in their planning of future improvements in Medicare data.

FUTURE STEPS

As a result of the limited time available to the Commission to prepare this first annual report, not all important topics in physician payment policy could be addressed. Those that have been deferred include specific steps to increase the quality of care, variation in payments by physician specialty, the use of surgical second opinions, per case payment of hospital-based physicians such as radiologists, anesthesiologists, and pathologists, and the payment for physician and other medical services through capitation arrangements. The Commission plans to take up these and other issues in the future.

The Commission's policy recommendations represent first steps in the process of reform. The workplan defines the effort required in the coming year to provide the basis for further recommendations for change. The Commission's work will focus on both refinements that address specific aspects of the current payment system--geographic variation in charges, inherent reasonableness, coding--and the development of a fee schedule that could replace the current method of payment. In addition, the Commission will begin to take up issues it did not have time to address prior to this report and new issues that arise in the policy debate during the coming year.

CHAPTER 1

INTRODUCTION

THE PHYSICIAN PAYMENT REVIEW COMMISSION

In the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), Congress created the Physician Payment Review Commission (PPRC) to provide advice on reforms in the methods used to pay physicians for services to Medicare beneficiaries. The Commission's thirteen members are appointed by the Office of Technology Assessment, which seeks nominations of individuals with expertise in physician payment from organizations representing physicians and the elderly as well as other groups and experts interested in Medicare physician payment. The PPRC began its work in November 1986.

The Commission plays four roles. First, it serves as a source of independent expert advice to Congress and to the Secretary of Health and Human Services. Its members represent a broad range of experience and perspectives on issues concerning the payment of physicians. The Commission provides an organized structure for them to share a common information base and to render collective judgments.

Second, PPRC provides opportunities for beneficiaries, physicians, and other interested parties to have their views considered in policy deliberations on physician payment issues. These groups participate in the nomination process leading to the appointment of Commission members. In addition, PPRC actively encourages interested parties to present their views through formal oral and written testimony and through informal advice and comment to Commission members and staff.

Third, PPRC conducts objective analyses to provide a basis for policy decisions to alter Medicare's method of paying physicians. Through its staff and consultants, the Commission analyzes options by using large-scale data bases, including claims files and surveys of beneficiaries and physicians, and reviews of the relevant literature.

Fourth, the Commission performs the design work necessary to implement major changes in physician payment. This work includes the use of both analysis and consensus panels to specify key program elements, identify data requirements for defining and implementing program policies, and analyze the implementation experience of existing models.

The PPRC is mandated to make recommendations to the Congress by March 1 of each year regarding adjustments to reasonable charge levels, modifications in the methods for determining rates of payment, and changes in the methods for paying physicians for services under the Medicare program.

In reaching its recommendations, PPRC is required to address specific issues related to physician payment, including the variation in payment rates among specialties and geographic areas, the inherent reasonableness of charges for specific services or procedures, methods for developing a relative value scale for physicians' services and physician participation in the Medicare program. The full Congressional mandate is reproduced in the Appendix.

The Commission intends to consider both short-term improvements in the current payment system and alternatives for more fundamental long-term reform. It will strive to align its short-term recommendations with longer-term objectives.

GOALS FOR PHYSICIAN PAYMENT POLICY

In assessing options for reform, the Commission is guided by a what it believes should be the goals of Medicare's approach to paying for physician services.

Access to Care. Reforms in the methods for paying for physicians' services must ensure that beneficiaries have access to medical care. In the short run, access reflects physicians' willingness to care for Medicare patients and patients' abilities to afford the care. In the long run, access also depends on the supply of physicians and their choices of location and specialty. For those beneficiaries electing to continue to receive care through the fee-for-service system, free choice of physician must be maintained.

Quality of Care. Reforms in the methods or levels of payment should maintain or improve the quality of care provided to Medicare beneficiaries. Beneficiaries should receive high quality care provided through efficient medical practice.

Financial Protection for Beneficiaries. Reforms in payment to physicians should maintain financial protection for beneficiaries. While some patient financial responsibility for the cost of care may be appropriate, levels of responsibility should not be so high that they prevent beneficiaries from gaining access to care or impose significant economic hardship. The Commission is particularly concerned with limiting the responsibility of beneficiaries for charges in excess of what Medicare allows.

Equity among Physicians. Reforms in the levels or methods of payment should increase equity among physicians, so that similar payments are made for similar services among similarly qualified physicians. Differences in payments for different services should broadly reflect relative costs, market conditions, and other appropriate factors.

Reduction in the Growth of SMI Outlays. Reforms in physician payment should slow the growth in federal outlays for Supplementary Medical Insurance. The growing burden on taxpayers, who underwrite 75 percent of program costs through general revenues, and beneficiaries, who underwrite 25 percent of the cost through premiums, is becoming an increasingly serious problem. One way to address the fiscal problem without shifting it to others is to encourage increased efficiency in the practice of medicine. This can be achieved through more appropriate payment incentives to physicians, improved review of how services are used, expanded research, and better education of physicians and beneficiaries. In evaluating policy changes that reduce outlays in Part B of Medicare, the potential for offsetting increases in outlays for Part A of Medicare must be considered.

Understandability. Reforms should make the method of paying physicians easier for beneficiaries, physicians, and the general public to understand. Physicians should know what charges Medicare will allow, and beneficiaries should be informed by physicians what they are expected to pay. Where feasible, this information should be provided before service is delivered.

Orderly Change. Reforms in the method of payment should be orderly and coherent. Short-term change should be consistent with long-term policy goals. The feasibility of administering the changes must be taken into account, especially in setting schedules for their implementation. As major reforms are implemented, monitoring their effects should be given high priority, because these effects are uncertain and midcourse corrections may be required.

Pluralism. Reforms in payment methods should accommodate the various ways health services are organized. Both fee-for-service methods and capitation should play a role in the delivery of medical care in the United States.

THE COMMISSION'S FINDINGS

In its study of Medicare's methods of paying physicians, the Commission has come to the following conclusions that will guide it in making specific recommendations.

Tradeoffs. Tradeoffs among the goals outlined above are inevitable. While certain goals can be achieved simultaneously--for example, more efficient medical practice and increased quality of care--conflicts among the goals may well arise. When tradeoffs must be made, access to care and financial protection for beneficiaries should not be sacrificed.

Relative Charges as a Guide to Relative Payments. Current differences in relative charges for physician services provide distorted signals to physicians and cause serious inequities among physicians. These

distortions and inequities may affect physicians' decisions concerning what services to provide, what specialty to train for, and where to locate a medical practice. These problems result from a market in which consumers have difficulty in shopping for prices and where uneven insurance coverage obscures the signals consumers are able to deliver. Careful attempts to develop relative value scales that take into account factors in addition to existing patterns of charges may lead to relative payments that will provide more appropriate signals to physicians.

Uncertainty in Medicine. Since medical care is both an art and a science, physicians' decisions will continue to be pivotal in the delivery of effective care. One central challenge to policy is to find a way to incorporate society's concerns about limited resources into physicians' decisionmaking while maintaining the physician's freedom and responsibility to exercise clinical judgment on behalf of the patient.

RANGE OF ALTERNATIVES FOR PHYSICIAN PAYMENT REFORM

There are four general alternatives for reforming the way physicians are paid: refining the current payment system, making payments according to a fee schedule, creating a system of all-inclusive fees for defined packages of services, and increasing the use of capitation payments. This section briefly describes the current Medicare physician payment system and summarizes the key elements of the options for reform.

When the Medicare program was adopted in 1965, policymakers specified broadly how the program should pay physicians. The intent was to win physicians' cooperation and give Medicare beneficiaries access to mainstream medical care. Payment was to be based on reasonable charges, which were each physician's actual charges, as long as they did not exceed his or her customary charges or the prevailing charges of other doctors in the community. These guidelines provided the basis for CPR, the "customary, prevailing and reasonable" method of paying physicians.

Many observers, however, recognized the inflationary potential of these guidelines. By increasing the proportion of patients with insurance that paid physicians on the basis of charges, CPR markedly increased physicians' incentives to raise their charges. This potential was realized, and a series of adjustments have been put in place to constrain increasing Medicare outlays for physician services. One significant adjustment came in 1972, with the adoption of the Medicare Economic Index (MEI) as a control on increases in prevailing charges over time. More recently, Congress has temporarily halted updating of reasonable charges, has limited payments for specific services, and has taken other measures to control escalating costs.

Nevertheless, dissatisfaction with Medicare's method for paying physicians is widespread. Spending for physician services continues to grow faster than other Medicare spending and faster than federal revenues. The CPR method provides incentives for excessive medical treatment. The payment structure that has evolved under it has created distortions in relative payment levels by type of service, site of service and geographic area. Finally, there is serious concern that the financial protection and access to care afforded beneficiaries by Medicare are deteriorating.

Refinements in CPR

Despite the problems associated with it and the likelihood of more fundamental reform, CPR will continue to be the primary method of paying for physicians' services while other alternatives are being developed. In this interim period, refinements in CPR would strengthen the capacity of the Medicare program to control both the cost and volume of services while maintaining financial protection for Medicare beneficiaries.

More aggressive efforts could be undertaken to adjust approved charges to minimize inappropriate differentials among types of services and geographic areas. Refining and standardizing codes to make them reflect more accurately the medical and surgical services provided could also slow the rate of Medicare expenditures.

More stringent controls on the volume of service could be implemented if Part B carriers expanded their current procedures for reviewing claims and more closely monitored patterns of physician practice and beneficiaries' use of services. The duties of Peer Review Organizations also could be expanded to encompass reviews of physicians' services for hospitalized Medicare beneficiaries and, more broadly, for ambulatory services (perhaps beginning with selected ambulatory services such as major procedures).

Expanded efforts to increase physician assignment rates through the participating physician program could be implemented to increase access and limit the out-of-pocket expenses of Medicare program beneficiaries. Such efforts become even more important as the introduction of further program restraints increase the likelihood of a decline in assignment rates with resulting increases in out-of-pocket costs for beneficiaries.

Fee Schedules

Introducing of a fee schedule for determining Medicare payments to physicians would retain the fee-for-service method of payment but could represent a major structural change from CPR. The fee schedule alters the relative payments to reflect differences in type of service and geographic area.

A number of difficult issues must be addressed in developing a Medicare fee schedule, particularly how to define the method for setting relative values for services and how to determine the way in which payments will vary among geographic areas, specialties and sites of service. These issues are addressed in chapter 3 below.

Because it is a fee-for-service payment method, a fee schedule shares some of the disadvantages associated with CPR. In particular, physicians would continue to have incentives to provide a high volume of services. Controls on the use of services may be able partly to offset this incentive. In addition, the potential for reductions in payment rates for some services as relative values are redefined requires finding ways to maintain or increase physician assignment rates as the fee schedule is implemented.

Payment for Specified Service Packages

Paying physicians a fixed fee for providing a package of related services would represent a fundamental change from the way physicians are paid under the current fee-for-service payment system. Changing the unit upon which payment is based could place physicians at financial risk by limiting them to a fixed payment regardless of the actual services provided.

The basis for such a system is a classification scheme that defines the kinds of services associated with the package being purchased. Global fees paid to surgeons provide one model of a service package with which there has been extensive experience. The nature of these categories could range from ambulatory visit or special procedure groups to episodes of care that encompass all inpatient and outpatient services associated with a given diagnosis.

Given the lack of experience and the difficulty in developing unambiguous units of payment, it has been suggested that such a method might be applied incrementally to selected services or procedures. The two options that have received the most attention are providing all-inclusive, diagnosis-specific payments for all inpatient physician services or for all inpatient services provided by hospital-based physicians such as radiologists, anesthesiologists, and pathologists. Defining the elements that make up different categories of ambulatory care is at a much earlier stage of development.

Since physicians would receive a fixed payment for all services provided for a defined episode of care, they would have an incentive to find the most efficient way to render care. There is the risk, however, that under such an arrangement medically necessary services might be underused. It also has been suggested that mandatory assignment would be a necessary component of this payment system so that any potential financial risk associated with the fixed payment would fall on physicians rather than on beneficiaries.

Capitation

The basic concept underlying capitation arrangements is that a fixed amount, set in advance and therefore independent of services actually used, is paid for each enrollee to a qualified entity that agrees to provide all covered medical services. Medicare currently offers beneficiaries the option of enrolling in Health Maintenance Organizations or Competitive Medical Plans that are paid on a capitation basis. Such risk-sharing health plans cover both hospital and physician services, and options to expand the proportion of Medicare beneficiaries covered by such arrangements could be applied to the full range of services or to physician services only.

The focus of options related to capitation is to improve those current arrangements offered by Medicare that have the potential to expand enrollment. These options include changes in in the ways qualified plans are regulated and refinements in methods of setting capitation payments.

Several other concepts, including vouchers and geographic capitation, are often confused with true capitation arrangements. These approaches focus on the delegation of insurance functions from Medicare to private entities and, in the view of the Commission, are not options for paying physicians.

As with any fixed-payment scheme, capitation creates incentives for the efficient production of services as well as risks that plans will select Medicare enrollees who are healthier than average and that medically necessary services will be underused. These risks must be addressed through the development of monitoring processes sensitive to underutilization and improvements in methods for setting capitation rates that account for expected differences among Medicare enrollees' requirements for medical care.

TIME FRAME FOR REFORM

The Commission believes that the changes associated with each alternative for reform require different time frames for implementation. Measures that represent the least change from the current CPR system can be adopted most rapidly. Those that represent more fundamental changes will require more time to design and implement. Because fee schedules retain fee for service as the basis for payment, and there is extensive experience with them in the United States and abroad, they are generally considered the most feasible of alternatives in the near term.

Each alternative has different implications for the program goals defined earlier in this chapter. The challenge is to develop a feasible alternative

that maximizes the net effects of tradeoffs between these different elements. The development work required to implement each alternative will vary depending on the degree to which previous experience can guide major design decisions, how much further analysis is needed to guide work on key program elements, and the nature of the process through which major decisions on program design are to be made. The extent of the development work thus influences the lead time necessary before each alternative could be undertaken.

It is likely, and indeed appropriate, that elements of each payment alternative will operate simultaneously in the physician payment system. Such coexistence of different payment mechanisms affords the Medicare program flexibility in its payment policy, allows new approaches to be tested and is consistent with a Medicare physician payment policy that already encompasses fee for service and capitation.

It is possible to apply each payment method broadly or selectively (a national fee schedule versus specialty-specific fee schedules, for example, or a case-based payment system for all physicians' services versus a per admission payment of radiologists, anesthesiologists, and pathologists). A major consideration for the Commission in evaluating policy options and setting an agenda for reform is that the changes adopted in the short term be consistent with the direction in which physician payment policy should move over the long term.

SCOPE OF THE REPORT

This first report to Congress focuses primarily on reforms to fee-for-service payment for physicians under the Medicare program. This focus stems from the Commission's belief that fee for service will remain the dominant method of payment for physicians for the foreseeable future. While PPRC will explore how alternative methods of payment might improve overall efficiency of the health care system, broader structural reforms in physician payment are beyond the scope of this initial report.

The issues addressed are those for which reform was considered to be politically and technically feasible in the near term. The report includes recommendations on immediate refinements in CPR to address the most pressing issues in the current payment system and on the direction for longer-term policy reforms. It also sets the agenda for the Commission's work in the coming year.

Subsequent chapters of the report present background analyses and Commission recommendations on the following issues: fee schedules, geographic variation in charges, inherent reasonableness, assignment and the participating physician program, the Medicare Economic Index (MEI), improving program administration, coding, data issues, and assistant at surgery.

The Commission deferred consideration of several issues raised before it. They are summarized briefly in this report and include: the influence of alternative payment mechanisms on quality of care, specialty differentials, second surgical opinion, payment of radiologists, pathologists and anesthesiologists on the basis of diagnosis-related groups, and capitation.

CHAPTER 2

BACKGROUND AND CONTEXT

In 1965, Congress added Title 18 to the Social Security Act, creating a new program of health insurance for the elderly. The new plan had two parts. Part A, the Hospital Insurance program, provided primarily for hospital inpatient coverage with limited home care and skilled nursing facility benefits. Part B, the Supplementary Medical Insurance (SMI) program, covered the costs of physician services as well as outpatient laboratory tests, durable medical equipment, outpatient hospital care, and certain other services.

Congress has changed many details of the Medicare program since 1965, but the basic structure of the program remained intact until 1983 when the cost-based method for paying hospitals was replaced by prospective payment. Changes in Part B have been less extensive.

This chapter provides an overview of the SMI program, its beneficiaries, and the physicians and other practitioners who serve them. Included in this review is a discussion of the program's "customary, prevailing, and reasonable" (CPR) method of paying physicians. This chapter also reviews relevant developments in the private sector. The concluding section summarizes the major criticisms directed at Medicare's physician payment policy--excessive costs, complexity, unpredictability, and inadequate protection of many beneficiaries.

SUPPLEMENTARY MEDICAL INSURANCE PROGRAM

Basic Features of the Program

The Supplementary Medical Insurance program was established as a voluntary, non-means-tested program. It remains so today. Beneficiaries' freedom to choose their physicians, hospitals, and other medical care providers was and is an important principle. Beneficiaries can enroll in a qualified Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP), where limits on their choice of provider are the norm. Nevertheless, the decision to join or to stay with the basic Medicare program remains with the beneficiary.

One further important principle in the original Medicare legislation was government noninterference with the practice of medicine. But Congress has since required that the appropriateness of hospital services be reviewed, initially by Professional Standards Review Organizations (PSROs) and later by Peer Review Organizations (PROs), and the scope of this review function has repeatedly expanded. In addition, the carriers who administer the SMI program are continually extending their review of the

appropriateness of Part B services. A variety of specific constraints on payment (restrictions on payment for assistants at surgery, for example) have been also implemented. Through these and other means, government has come to exert considerable influence on medical practice.

The remainder of this section covers such basic features of the SMI program as eligibility and enrollment, covered and noncovered services, beneficiary cost sharing, financing, and administration. The high and increasing level of SMI expenditures is also described.

Eligibility and Enrollment. Most Americans age 65 and older are entitled to receive hospital insurance benefits under Medicare Part A. Those individuals eligible for Part A and anyone older than age 65 can also obtain Part B coverage by paying a monthly premium. The 1972 Social Security amendments extended Medicare eligibility to many disabled individuals and certain individuals with end-stage renal disease, but the elderly still constitute 90 percent of Medicare enrollment.

In 1985, about 27 million aged and 3 million disabled persons were entitled to benefits for hospital insurance. Of those beneficiaries, virtually all of the aged and about 92 percent of the disabled chose SMI coverage. Further discussion of program beneficiaries will focus on the aged.

Between 1981 and 1985, growth in the Medicare enrollment rate for the aged averaged just over 2 percent annually. This rate is expected to decline slightly and then accelerate as the baby-boom generation begins to reach age 65 about 2010.

Coverage. Medicare covers primarily acute care services deemed medically necessary. Part A coverage emphasizes institutional services, mostly inpatient hospital care, with more limited coverage for care by skilled nursing facilities, hospices, and home health agencies.

Subject to various limitations, SMI covers physician services, including inpatient and ambulatory surgery, consultations, and visits in the hospital, home, or office. A restricted range of services by chiropractors, dentists and podiatrists is also covered, along with hospital outpatient services, outpatient laboratory and X-ray tests, freestanding ambulatory surgery, outpatient rehabilitation and physical therapy, and a few other services. The costs of durable medical equipment and some medical supplies are also covered. Medicare has not significantly expanded its range of covered services since the program began.

Services not covered by Medicare include long-term care, outpatient prescription drugs, routine visual and hearing exams, most glasses and hearing aids, prophylactic dental care and dentures, most routine foot care, and most preventive services such as physical exams and influenza immunizations. Other services, such as outpatient mental health care, have benefits so limited that they may be considered noncovered.

Noncovered services and those with limited coverage are usually paid for by the aged or their families and, less frequently, by private supplemental insurance. Medicaid pays for services for some people with very low incomes. The extent to which people simply go without needed services or receive more intensive services than necessary because less intensive alternatives are not covered is unknown.

Beneficiary Cost Sharing. Before SMI benefits begin, enrollees must meet an annual deductible of $75 paid against charges allowed by Medicare. Once the deductible is met, the beneficiary is liable for 20 percent of Medicare allowed charges for covered physician services. There is no upper limit or cap on beneficiary financial liability for this coinsurance liability.

Beneficiaries may also be liable for "balance bills" from physicians when the charges exceed those approved by Medicare. There is no balance bill when the physician accepts assignment for the claim, that is, agrees to accept Medicare's approved payment and the required beneficiary cost sharing as payment in full. Assignment and physician payment issues are treated in depth throughout this report.

Administration. The processing of Part B claims is delegated to private contractors known as carriers.[1] The Health Care Financing Administration manages the contracting process, sets performance standards, evaluates carrier performance, and reports key program data. Program administration is discussed in chapter 8.

Financing. The SMI Program is financed by a combination of beneficiary premiums, general revenues, and trust fund interest. To obtain coverage for SMI benefits, enrollees must pay a monthly premium of $17.90, or $214.80 a year in 1987, up from $36 a year in 1966.

Until 1972, premiums were to cover half of program costs and general revenues the rest. But as outlays escalated during the early years of the program, Congress limited increases in beneficiary premiums to the percentage cost-of-living increase in Social Security cash benefits. Any resulting shortage was to be covered by additional funding from general revenues. By the end of the 1970s, premiums accounted for less than one quarter of program costs. Subsequent legislation required that premiums cover 25 percent of SMI costs through 1988, with the restriction that yearly premium increases for each enrollee could not exceed the dollar level of Social Security cost-of-living adjustments. In 1983, premiums accounted for 22.3 percent of SMI funds; by 1985, the figure had risen to an estimated 23.5 percent.

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[1]One exception is that Part A contractors, or intermediaries, pay claims for outpatient hospital care.

Because contributions from general revenues must make up the difference between premium income and program costs, the solvency of the SMI trust fund is not directly endangered by rising benefit outlays. Instead, the burden falls on general revenues and thereby contributes to the budget deficit.

Rising Federal Outlays

Both the high absolute level of spending for Medicare and the high rate of spending growth have made the program a major target of policy reform and budget control efforts. Federal outlays for Medicare amounted to nearly $76 billion in fiscal year 1986. This represented about 8 percent of the entire federal budget and almost 2 percent of the gross national product.

SMI accounts for about a third of total Medicare spending, more than $26 billion in Fiscal Year 1986. Physician services specifically accounted for about 75 percent of SMI expenditures. Although their services make up less than 25 percent of all Medicare spending, physicians may actually influence more than 70 percent of other medical services used by beneficiaries (Blumberg, 1979). Therefore, any reforms in the current payment method for physicians need to be considered in light of their more general consequences for health care delivery and spending.

SMI expenditures have grown at a rate that exceeds the rate of spending growth for the Medicare program as a whole. Between 1975 and 1985, SMI expenditures increased an average of 18 percent a year. An Urban Institute study of the period 1975 to 1982 separated the Part B spending increase into the following components (Juba and Sulvetta, 1986):

- o general price inflation (7.4 percentage points),
- o services per enrollee (6.0 percentage points),
- o inflation-adjusted Part B payments per service (2.3 percentage points),
- o enrollment (2.3 percentage points).

These figures indicate that increases in Part B payments per unit of service (adjusted for general inflation) have been only one factor in the escalation of Part B spending. General inflation and the increase in the volume of services for each enrollee have been more significant.

The increase in the volume of services needs to be kept in mind as alternative physician payment methodologies are evaluated because the method of paying physicians affects not only the unit price of services but the number of services provided. For example, savings achieved through freezing fees and other constraints on unit payments may be more than offset by increases in service volume, some of which may

occur in response to limited payments. The Commission's recommendations regarding changes in the ways Part B payments are determined will be sensitive to such interactions.

Although no analysis of more recent data documents this, the relative weights of factors causing increases in costs have almost certainly changed since the Urban Institute study. At least three reasons can be cited: a freeze on physician fees was in place from July 1984 through April 1986, with the freeze on nonparticipating physicians extended through December 1986; the volume of claims has grown markedly since 1984; and general inflation has dropped dramatically. HCFA is now studying the impact of the fee freeze on SMI outlays. A better understanding of all the factors contributing to the growth in the volume of claims and in total outlays is one of the Commission's objectives in the coming year.

BENEFICIARIES

The structure of the SMI program and the characteristics of its beneficiaries interact to influence both the levels of program costs and the degree of financial protection the program provides to beneficiaries. This section briefly describes the demographic and economic characteristics of the elderly and summarizes the variable patterns of medical care use and spending within this population. Two important conclusions emerge. First, the aging of the U.S. population will impose substantially increased pressure on Medicare expenditures and resources. Second, the burden of health care costs falls unevenly among the elderly. The less well off (disproportionately women or minorities), the very sick, and the heavy users of noncovered services are the most vulnerable.

Demographic Characteristics

Today, those age 65 and older account for about 12 percent of the population. This figure will grow to 13 percent by 2000 and to 22 percent by 2050. Further, the aged group is itself aging. In 1980, 39 percent of this group were 75 years and older. This cohort is projected to account for half of all aged by 2000 and 55 percent by 2050. The very old population, those 85 and older, is the fastest growing age group. It is expected to triple by 2020 and to increase sevenfold by the middle of the next century (Special Committee on Aging, 1986).

Economic Status

Overall, the economic condition of the elderly has improved substantially in recent years (Gordon, 1986). From 1969 to 1984, the poverty rate for the elderly was halved. Cash income rose 18 percent after adjustment for inflation, primarily because of increases in Social Security benefits. In many respects the aged fared relatively better as a group than did younger people. Nevertheless, a sizable segment of the over-65

population is poor or near-poor. Particular segments of the elderly--minorities, women and the very old--suffer disproportionately from poverty (Special Committee on Aging, 1986).

The overall rate of poverty among the aged in 1984 was a little over 12 percent (Gornick, et al., 1985).[2] This is slightly greater than the level for other adults but is lower than that for children, about one out of five of whom are poor. However, almost 17 percent of the elderly were near poor (in families with incomes between 100 and 150 percent of the poverty level) compared with 10 percent of the nonelderly. Large expenses, such as those for a major illness, could reduce many of the near-poor to poverty status.

In-kind benefits, primarily Medicare, make a significant--albeit difficult to measure--contribution to the well-being of the elderly (Gordon, 1986). Medicare provides a valuable insurance against risk for all beneficiaries, even those who do not have any actual payments made on their behalf during a particular year. In recent years Medicare has made some payments for medical services for about two-thirds of the elderly. About 36 percent of the elderly poor are also covered by Medicaid, but states vary considerably in the level and type of protection they provide. Other important in-kind benefits include food stamps and housing assistance.

Economic well-being varies considerably within the aged population. For example, in 1983, the age 85 and over group had nearly twice as many people below the poverty level (21 percent) as did the age 65 to 74 cohort (12 percent).

About ten percent of elderly whites are counted as poor. The poverty rate for elderly blacks is triple this; for Hispanics, double. Overall, not quite nine percent of aged men are poor; for aged women the figure is 15 percent. The group worst off is that of elderly minority women living alone--nearly 60 percent are poor.

Utilization of Medical Care

The use of health care services tends to increase with age.[3] Older people are hospitalized about twice as often and stay twice as long as the general population. Although only 12 percent of the population, the elderly accounted for approximately 28 percent of all those discharged from hospitals in 1983.

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[2]In 1984, the poverty threshold for a two-person household headed by a person 65 or older was $6,282; for one person it was $4,979.

[3]Most of the data in this section come from the Health Interview Survey (National Center for Health Statistics, 1985b), including unpublished data, and the National Hospital Discharge Survey (National Center for Health Statistics, 1985a).

The elderly have higher rates of chronic illness than the rest of the population and are particularly vulnerable to certain medical problems. The elderly account for about 80 percent of pacemaker and lens insertion/extraction procedures, about 75 percent of prostatectomies and hip replacements, and more than a third of all mastectomies (Burney and Schieber, 1985).

The elderly have more physician visits, averaging about seven and a half visits a year versus five for younger people. They also use about two times more prescription drugs and medical equipment and supplies.

The use of services varies somewhat within the aged population as well. During 1984, those aged 65 to 74 averaged not quite eight physician visits a year versus more than nine for those age 75 and older; those aged 70 to 74 accounted for about $485 in Part B reimbursements per person, whereas those 85 and older had per person reimbursements of nearly $600 per person.

The pattern of health care utilization among the elderly deserves special attention as policy reforms are contemplated. In many respects, Medicare is based on a model of insurance coverage designed for a population that is younger and employed. The current debate over coverage for catastrophic illness, particularly coverage for long-term care, reflects society's problems of moving Medicare toward a model more congruent with its beneficiaries' needs.

Financial Burden of Medical Care

The financial burden of medical care is a function of several interacting variables. The greater the use of care, the greater the potential liability. The greater the use of noncovered services, the greater the burden. Those who are too poor to afford private supplemental ("Medigap") coverage but who are not eligible for Medicaid are particularly vulnerable.

Out-of-Pocket Spending. Spending for health care services poses a substantial financial burden on the aged. Out-of-pocket spending for direct medical expenses and for insurance premiums accounts for about 15 percent of the elderly's income (Congressional Budget Office, 1986).[4] This proportion is about what it was before the enactment of Medicare. However, during this period, overall health spending as a percentage of GNP almost doubled.

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[4]The Congressional Budget Office defines out-of-pocket costs as the share of charges for specific services paid by patients, including payments for completely uninsured services, deductibles, coinsurance, and billed amounts in excess of insurer-approved levels.

The financial burden of medical care falls most heavily on those with very large medical bills and little or no supplementary coverage. Medicare data show that a small proportion of beneficiaries account for a large share of total approved charges for physicians' services. In 1983, the 6 percent of beneficiaries who reached $2,500 or more in approved physician charges accounted for 45 percent of all approved charges; the 15 percent of those with approved charges totaling $1,000 or more produced 73 percent of all allowed charges. In contrast, the 66 percent of beneficiaries with approved charges less than $250 accounted for only 7 percent of expenditures (Burney and Schieber, 1985).

These figures cannot be translated directly into information on beneficiary liability for physician services, but other information suggests the potential burden (Gordon, 1986). For example, beneficiaries who generate no Medicare reimbursements have an estimated potential out-of-pocket liability somewhat over $250 (including the SMI premium and, perhaps, some costs below the deductible). This figure rises to $1,550 for beneficiaries who were hospitalized at least once and to $14,270 for beneficiaries hospitalized long enough to draw on their Part A lifetime reserve days.

A hypothetical example illustrates the potential burden on beneficiaries created by even a relatively moderate amount of illness (Davis, 1986, updated).

Medicare Part B premium	$215
One hospital deductible	520
Part B deductible	75
Part B coinsurance on a $2575 physician bill (after deductible)	500
Outpatient prescription drugs	500
Miscellaneous	250
TOTAL	$2,060

For an individual on a limited income and without "Medigap" or Medicaid protection, this $2,000 expense would be a substantial burden (without SMI coverage, the figure would exceed $3,800). The individual with private supplemental insurance would receive some relief on the deductibles and coinsurance but might have to pay several hundred dollars in premiums for that protection.

As technology provides more options for noninpatient services and payers continue to seek reductions in unnecessary inpatient care, the limits of Medicare coverage for nonhospital services may become a significant problem. For example, many patients no longer need to be hospitalized to receive intravenous antibiotic therapy. People who receive such treatment at home may face less risk of iatrogenic disease and may have more comfortable surroundings, but they may find the treatment a financial burden because Medicare does not cover the costs of outpatient prescription drugs.

Other liabilities have arisen as more and more constraints on the CPR payment methodology have been added. For instance, if a lab test is performed in a physician's office and the physician does not take assignment, that is, does not agree to accept Medicare approved charges as payment in full, then the tests are not reimbursed. Many beneficiaries are unaware of this potential expense, although no data are available on the extent to which this rule is a problem.

Rules limiting Medicare coverage combined with other provisions of the law, such as those for paying physicians, have created a complex program for beneficiaries and practitioners to navigate. Unintended and unwanted consequences can easily escalate, creating unanticipated and sometimes heavy financial burdens for beneficiaries and distorting the appropriate and possibly cost-saving use of preventive services, home care and other alternatives to hospitalization. If reform of Medicare payment for physician services reduces spending, considerations of beneficiary financial protection, access, and quality of care may make it wise to channel some of these savings into services currently not covered.

Medigap. About 70 percent of Medicare beneficiaries have some protection beyond Medicare through private supplemental insurance, commonly referred to as Medigap. Medigap policies are primarily designed to cover part or all of the Medicare deductible and coinsurance for covered services plus hospital expenses beyond Medicare limits. Protection against balance billing is less common, as is protection for noncovered items, such as drugs. Insurance for the expenses of long term care is rare.

For those who have additional private coverage, the risk of high out-of-pocket expenses is markedly reduced. Beneficiaries without such protection who have more than 60 days of hospital care can face average out-of-pocket costs of over $10,000. For those with private supplemental coverage, the average liability drops to less than $2,000 (Gordon, 1986).

The cost of Medigap policies generally averaged about $300 to $400 per subscriber in 1984. It can range from $150 to more than $1,000, depending on benefits, administrative costs, and profit margins. For some retirees, supplemental coverage is fully or partially paid by a former employer or a union, and the scope of coverage may largely match that provided for active employees.

Medicaid. About 10 percent of Medicare beneficiaries also have Medicaid coverage, which picks up required beneficiary cost-sharing and certain additional services. The federal government specifies minimum and optional benefits for state Medicaid programs for which federal matching funds will be available. States vary in the extent to which they provide additional benefits. Physicians who treat Medicaid beneficiaries must take assignment to be reimbursed.

Those able to receive both Medicare and Medicaid benefits, the "dual eligibles", are more likely to be elderly, female and members of minority groups than the Medicare population as a whole. They also tend to use more health care services. Many Medicare beneficiaries become eligible for Medicaid because their large medical bills, when deducted from their incomes, drop them below the poverty threshold.

The fact that 70 percent of Medicare beneficiaries are covered by Medigap policies and 10 percent are eligible for Medicaid means 20 percent of beneficiaries are without either source of additional protection. These beneficiaries tend to be older and sicker than the general population and have incomes that are lower but too high to qualify for Medicaid. Any increases in Medicare cost-sharing or limitations in coverage fall particularly hard on this group.

Physician Acceptance of Assignment. A physician's decision to refuse assignment can affect beneficiaries' out-of-pocket liability, sometimes making needed care too costly. However, higher out-of-pocket expenses will result only if the physician does, in fact, bill for an expected balance of charges beyond the level allowed by Medicare.

Assignment rates vary according to a beneficiary's age and race. The most current disaggregated data available are for 1982, when acceptance of assignment for charges was 52 percent overall. The rates ranged from 47 percent for the young elderly (ages 65 to 69) to 61 percent for the old elderly (age 85 and older). Rates for women and men were about the same, just over 50 percent. Rates for nonwhite beneficiaries exceeded rates for whites, 80 percent compared with 49 percent (McMillan, Lubitz, and Newton, 1985). The Commission is not aware of any research that attempts to discern whether this pattern reflects physicians' accepting assignment more readily when patients are less well off or whether such patients are more likely to use physicians that generally accept assignment. That physicians are required to accept assignment of charges for those patients eligible for both Medicare and Medicaid may also be a factor.

PHYSICIANS AND OTHER PRACTITIONERS

About a half million physicians practice medicine in the United States, and a great many other practitioners provide a wide range of medical services either independently or under a physician's supervision. Medicare has a substantial impact on most physicians and practitioners, and they, but particularly physicians, have a significant impact on Medicare. This relationship is a dynamic one and is affected by many factors, among them, the number and distribution of physicians and other practitioners, the organizational environment in which they practice, and the goals and strategies of public and private payers.

Physician Supply

Perhaps the most important factor that will influence the two-way relationship between Medicare and physicians in coming years is the continuing growth in the number of physicians. This growth has implications for what policy changes Medicare may adopt and how physicians may react to such changes. The increasing supply is also affecting how physicians practice medicine and how they arrange their practices. Collectively, these developments will affect the quality, availability, and cost of patient care.

From 1970 to 1980, the number of physicians in the United States grew from 156 to 197 per 100,000 population. By 1990, the number is expected to reach 235 per 100,000 (Public Health Service, 1986). Some have warned that the nation faces an expensive oversupply of physicians, although this contention is not universally accepted and recent revised projections have shown less substantial levels of oversupply by the end of the century (Harris, 1986; Public Health Service, 1986).

Distribution of Physicians. In theory, the growing number of physicians should help ameliorate--albeit at a high cost--the shortages experienced by certain areas of the country. Some analyses indicate that this growth has supported a geographic diffusion of physicians, particularly specialists, into less urbanized areas (Newhouse et al., 1982). The picture with respect to primary care practitioners is more complex, given the declining numbers of traditional general practitioners, the growing numbers of family practice specialists, and the possible differences in the locations each category of physician prefers.

Physician Supply and Costs. The effect of the growing supply of physicians on health care spending is another subject of considerable debate. One estimate is that the elasticity of expenditures for physician services is 0.4; that is, every 10 percent increase in the number of physicians produces a 4 percent increase in expenditures on physician services (Sloan and Schwartz, 1983). Other studies show contradictory results (Luft and Arno, 1986). Regardless of what the patterns have been in the past, however, health care delivery and payment systems are undergoing too many changes to permit automatic assumptions that they will continue.

Physicians' Incomes. Despite the increase in the number of physicians, net incomes from practice have not declined. Net incomes in 1985 averaged $113,200 (American Medical Association, 1986). After adjustment for inflation, average net income was virtually unchanged between 1975 and 1985. However, relative to all full-time-equivalent workers in the United States, physicians' incomes rose 4 percent during this period. While some analysts have projected declines in net incomes as a result of increasing competition, these changes have not yet been pervasive enough to affect the aggregate results.

There are significant differences in income according to medical specialty, and the differences have been growing over time. Surgeons, radiologists, and anesthesiologists have the highest incomes; pediatricians, general and family practitioners, and psychiatrists have the lowest. Surgeons' incomes in 1985 averaged $155,400, which was 37 percent above the average compensation for physicians.

Physician incomes also show considerable geographic variation. In 1985, net income varied by census division from an average of $97,500 in the mountain states to $123,300 for the east south central area. Mean income in nonmetropolitan areas was $94,200; it was $118,100 in metropolitan areas with populations smaller than 1 million and $112,800 in metropolitan areas with populations of more than 1 million.

Other Practitioners

Medicare covers a very limited range of services provided by such nonphysicians as chiropractors, dentists, and podiatrists. These practitioners operate without the supervision of a physician and can bill Medicare directly for their covered services.

In addition, other practitioners--physicians' assistants, nurse practitioners, and certified nurse-midwives--now provide certain services traditionally provided by physicians. These practitioners typically operate under direct physician supervision. Third-party payers usually do not cover their services explicitly, and even when such coverage is explicit, billing is typically through a physician or other employer. Medicare provides limited explicit coverage for physicians' assistants who furnish services under physician supervision in a hospital, skilled nursing facility, or intermediate care facility. The physician or other employer bills Medicare for these services.

Today, there are over 15,000 nurse practitioners, 16,000 physicians' assistants, and 2,000 certified nurse-midwives (Office of Technology Assessment, 1986). Analysis by the Office of Technology Assessment indicates that within their areas of competence, the quality of service provided by these practitioners is equivalent to that of physicians and is also cost-effective.

The major impetus for the development of these practitioners came in the 1960s when there was a perceived shortage and maldistribution of physicians. However, as the supply of physicians grows, the role of these practitioners--particularly in the fee-for-service sector--has become more uncertain.

The Malpractice Issue

Considerable attention is being paid to the issue of physician malpractice, the burden of high premiums for liability insurance, and the

appropriateness of the current tort system as a vehicle for deterring poor practice and compensating the victims of it. Unfortunately, more questions are being raised than answers agreed upon (Bovbjerg, 1986).

With respect specifically to Medicare policy, there are several concerns. One involves Medicare's payment method. Should there be any adjustment in payment levels to reflect the increasing burden of malpractice premiums, particularly for those physicians most severely affected? Equity for physicians is a concern but a higher priority is to ensure that beneficiaries' access to care is not impeded by physicians who limit their practices to reduce malpractice risks. Partly out of concern about decreased access to maternity services in some locales, a few private payers have made limited payment adjustments for obstetrical services, a specialty that incurs high insurance premiums.

Another issue for Medicare is whether the practice of defensive medicine has increased the use and cost of services, and whether the quality of care has been affected. Defensive medicine complicates the workings of utilization review and quality management programs.

Organizational Context of Medical Practice

Increasingly, physicians are practicing as members of some sort of organized group (American Medical Association, 1986). Between 1975 and 1983, the percentage of solo practitioners declined from 54 to 49 percent, and the percentage practicing in groups of five or more physicians increased from 17 to 23 percent.

As physicians move away from solo practice and two- or three- person groups, a trend that is by no means complete, new methods of physician payment, such as capitation, become more practical. What is an unacceptable and unreasonable financial risk for the individual physician becomes a more manageable shared risk for large groups, clinics and medical staffs.

Although not directly reflected in the practice statistics, another important change in the organizational context of practice is the growing importance of the hospital medical staff. The medical staff has taken on new roles with the imposition of prospective payment, the growth of hospital sponsored health benefit plans, and the increased concern over hospital liability for malpractice. Some proposed physician payment methods, such as inpatient DRGs, could markedly increase this interrelationship.

Medicare and Physicians

Payments. In 1985, Medicare beneficiaries accounted for about one-third of the average physician's visits; perhaps one-fifth of gross physician income came from Medicare sources. The economic impact of Medicare on physicians is difficult to document precisely, but it does

appear to vary appreciably from specialty to specialty. One survey, for instance, found thoracic surgeons reporting 35 percent and internists 29 percent of gross earnings from Medicare compared with 15 percent for family practitioners (Owens, 1983). Medicare is a particularly important component of payments for inpatient physician services. It is generally suggested that Medicare can be more influential where it accounts for a larger fraction of physicians' incomes.

Assignment and Participation. In 1986, 68 percent of charges for physician services were assigned. No current disaggregated data are available, but an analysis of 1983 data, when the overall assignment rate for charges was 52 percent, showed considerable variation in acceptance of assignment by specialty.[5] Psychiatry, gastroenterology, and pulmonary disease have relatively high assignment rates (72 to 65 percent); anesthesiology, otolaryngology, ophthalmology, and general practice each had rates less than 45 percent (Burney and Schieber, 1985).

Utilization Control. Physicians are facing an increasing array of public and private programs designed to monitor, analyze, and influence their patterns of medical practice. Until the adoption of Medicare's prospective payment system for hospitals, the federal government's attention focused primarily on overuse of services. For hospital admissions and out-of-hospital services, this concern remains; PRO and carrier review of potential overuse continues to be a fact of physician life. Added to the concern about overuse of services is an interest in identifying and preventing any underuse of necessary services once a hospital stay is initiated. The growth of Medicare beneficiary enrollments in capitated payment plans such as HMOs is stimulating efforts to measure and ensure appropriate levels of use for nonhospital care.

DEVELOPMENTS IN THE PRIVATE SECTOR

Medicare is not alone in experiencing a crisis in health care costs nor in devising a wide array of hoped-for solutions. Private insurers and employers are feeling the impact of an aging work force, a growing unfunded liability for retirees' health benefits,[6] and the transfer from Medicare of primary responsibility for coverage of the working aged. In

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[5]The 1983 and 1986 data are not fully comparable because the 1983 data include assignment figures for clinical lab charges. Since the adoption of the physician participation program and the requirement that clinical lab claims have to be assigned, assignment data are now disaggregated for the two categories. This separation is not possible for the 1983 data.

[6]This liability is a significant concern. Estimates of unfunded employee insurance liabilities, most of it involving health benefits, range from $100 billion to over $2 trillion (U.S. Department of Labor, 1986).

addition, union contracts and competition for white-collar workers have spurred expanded coverage for drugs, dentistry and other services not covered by Medicare.

Because no single decisionmaker sets policy for the private sector, diversity is the mark of private initiatives. Nevertheless, some broad patterns can be discerned: a move toward self-insurance, greater employee cost sharing, employee choice among alternative health plans, and more intensive application of such benefit management techniques as utilization review. There has been a comparatively low level of innovation in physician payment methods.

Self-insurance and Cost Sharing

Following the rapid escalation of health care costs in the 1970s, many employers focused their cost-management efforts on self-insurance and related vehicles for avoiding the underwriting charges and cash flow demands of an insured benefit plan. Plan administrators, no longer full-scale insurers, were placed under extreme pressure to reduce their administrative fees.

A second major thrust of employer's cost-control efforts was to increase cost-sharing for employees. The intent was to transfer a greater share of benefit expenses to workers and, if possible, to let higher out-of-pocket costs reduce demand for care.

Gradually, many private employers came to believe that these financial and cost-transfer mechanisms, although worthwhile, were of limited effectiveness in controlling benefit cost inflation. Bare-bones administrative costs, in particular, could mean uncontrolled benefit outlays because audit, utilization review, provider education, and data analysis functions were necessarily weaker. And many employers felt that beyond a one-time reduction in expenditures, cost sharing could do little more to cut benefit expenses except at levels that were unacceptably high.

Employee Choice and Benefits Management

Many employers have accepted the thesis that allowing employees to choose among competitive health plans could cut their total health benefit costs. HMOs and preferred provider organizations (PPOs) are increasingly being offered as alternatives to traditional programs. But some employers are now questioning whether the lower utilization rates and the sometimes lower premiums of HMOs and PPOs are reducing employer's total costs. They suggest that the premium setting provisions of the federal HMO Act, combined with the tendency of healthier employees to choose the new options, has diverted potential program savings from the employer to the HMO or PPO. Moreover, the administrative demands of offering a large number of options are a growing concern.

Employers and insurers have devised a variety of new benefits management tools aimed primarily at controlling costs in traditional health benefit programs. These tools include intensified audits of bills, redesigned benefits to encourage substitution of lower-cost services, preadmission review of hospital admissions, high cost case management, and expanded analysis of physician practice patterns, with remedial action directed at aberrant providers. Many of these programs have shown encouraging initial results but some diminishing of later returns. Benefit managers are debating whether the programs, which may be relatively expensive and intrusive, can be dropped or scaled back without a return of the inappropriate practices which predated them.

Physician Payment Methods

One intriguing picture that emerges from a review of private sector initiatives is the relative absence of recent innovations in physician payment methods. Contractual relationships between payers and physicians have multiplied, and these contracts typically specify a payment method other than billed charges. However, the method is ordinarily a simple discount from billed charges, less often a fee schedule derived from historical charge data. Either approach may be accompanied by a partial retention of payments to permit a bonus at the end of the year for lower-than-expected service volume or a cushion for utilization that exceeds target levels.

In sum, the private sector has so far not moved significantly to change physician payment, whether the change is to initiate a fee schedule, move to capitation, or adopt some other approach. This situation probably reflects four factors:

- o uncertainty as to the implications of payment alternatives;
- o continued preoccupation with bringing hospital costs under control;
- o union contracts that specify a particular physician payment methodology (typically "usual, customary and reasonable," the private sector's version of Medicare's CPR method); and
- o limited data and purchasing power for most fee-for-service programs, with the exception of some Blue Cross and Blue Shield plans.

Relation to Medicare Program

Medicare policymakers are very much alert to private-sector innovations. Some strategies, such as expanded HMO options for beneficiaries, have been adopted after demonstration projects have tested their applicability to Medicare. The participating physician program also reflects private-sector developments. Other strategies have been rejected or adopted only

after considerable modification. For example, Congress rejected a general requirement that beneficiaries obtain second opinions for selected surgical procedures. It opted, instead, for a presurgery screening program with second opinions required only when a review decision is not clear-cut.

If Medicare adopts a fee schedule, some private payers who now pay on the basis of billed charges or CPR-type payment methods may follow. Few private payers have adopted DRG-based hospital payment, despite high levels of initial interest. However, a fee schedule may be an easier precedent to implement, especially if some technical features, such as area cost differentials and relative value scales, can be copied. (For pediatric, obstetrical, and other services uncommon in Medicare, additional development work would be needed.) Various kinds of private sector fee schedules do, in fact, exist already, but their effectiveness is essentially unevaluated.

The models of fee schedule development and cost projection that Medicare would provide could influence private decisionmakers. Nevertheless, a lot of work would remain to develop non-Medicare based conversion factors and other necessary elements of private-payer fee schedules. Moreover, the cost implications and the impact on private participating physician networks (Blue Shield, for example, or PPOs) might not follow the results expected for Medicare and could lead to different decisions.

THE CPR METHOD OF PAYMENT: CHARACTERISTICS AND PROBLEMS

Since its inception, Medicare has determined payment rates for physician services through a method referred to as customary, prevailing and reasonable (CPR). Under CPR, payment for each service is limited to the lowest of:

- the physician's actual charge;
- the physician's customary charge for that service (defined as the physician's median charge for the service during a prior 12 month period); or
- the prevailing fee for that service in the community, currently at the seventy-fifth percentile of customary charges of all physicians in that community. (Since 1976, the prevailing charge has been adjusted by the Medicare Economic Index which is discussed in detail in chapter 7.)

Criticisms

The CPR payment method has been criticized for providing poor incentives to deliver cost-effective services. In particular, it has been criticized for:

- encouraging inflation from increases in physicians' charges and the volume of services;

- creating patterns of allowed charges that embody inappropriate incentives for the use of medical services as well as for physicians' decisions on where to locate and what to specialize in; and

- being administratively complex and difficult for both physicians and beneficiaries to understand.

Some of the unwanted effects of the current payment system result from paying physicians on a fee-for-service basis. Other fee-for-service methods, such as fee schedules, may not be able to escape these problems. Unwanted effects also result from the particular structure of relative and absolute allowed charges and the mechanism through which they are determined under CPR.

Particularly as originally designed, the CPR method had inherent inflationary tendencies because physicians' maximum allowable payment levels were based, in part, on their actual charges in the previous twelve-month period. They thus had an incentive to increase current charges to avoid limits on future charges. This incentive remains to some extent, although the Medicare Economic Index has moderated its effects.

The CPR system shares with any fee-for-service system the absence of financial incentives to limit the volume of services provided to patients. Between 1975 and 1982, the volume of service per Medicare enrollee increased at an average annual rate of almost 6 percent (Juba and Sulvetta, 1986). While an important part of this increase undoubtedly reflects the availability of new services from developments in medical technology, some portion may reflect increases in the number and type of services provided by physicians to compensate for reductions in unit payments.

The current fee structure under CPR has raised concerns about the extent of variation in payment levels. When the Medicare program was established, the CPR system was adopted in part because it recognized variations in charges for physician services. These variations were thought to reflect differences in patient preferences and physician behavior as mediated through established markets for physician services. If Medicare payments departed much from the going market rates, then Medicare beneficiaries might not have access to care comparable to that of other Americans. Such comparable access is an important program objective.

Over the two decades that CPR has been used, a set of relative values for medical services has evolved based partly on these historical fee

patterns, partly on the introduction of Medicare fee constraints, and partly on carriers' discretionary definitions of geographic, specialty, and other payment subdivisions. This process has resulted in wide payment differentials among types of procedures, localities, specialties, and sites of care that cannot be explained fully by documented differences in the costs of physicians' practices.

Although these differentials have not arisen from deliberate decisions to favor certain styles of practice on grounds of cost, quality, or access, they may nevertheless affect styles of practice because they provide inappropriate financial incentives that influence such decisions as what services to employ in the care of patients, where to practice, and whether to specialize. These distortions can reduce access to care and quality of care as well as increase Medicare program costs. They have been criticized as being inequitable for both physicians and beneficiaries.

Changes in Method

While the basic structure of physician payment under Medicare has remained intact since 1965, several measures have been adopted to contain cost increases. In amendments enacted in 1972, the Medicare Economic Index (MEI) was introduced to limit increases in prevailing fees. This created the adjusted prevailing charge, defined as the prevailing charge in June 1973 inflated by an index of earnings and practice expenses. By limiting increases in the prevailing charges, much of the inflationary link between actual charges and Medicare payment rates was broken. In 1987, about half the approved charges are estimated to reach MEI ceilings (Congressional Budget Office, 1986). Because actual charges tend to increase at a more rapid rate than the MEI, the impact of the index is expected to strengthen slowly over time as higher proportions of approved charges are limited by the adjusted prevailing fees. (For further discussion of the MEI, see chapter 7.)

In addition to imposing the MEI limits, Congress eliminated the annual update in reimbursement rates that would have occurred in July 1984 and froze payment rates to physicians until October 1, 1985. That initial freeze was extended to May 1, 1986, for physicians who signed agreements to accept Medicare's approved charge as payment in full for services provided to all their Medicare patients (participating physicians). For other physicians, the freeze was extended to January 1, 1987. Congress took the further step in 1986 of limiting allowable increases in the actual charges of nonparticipating physicians once the freeze on charges was lifted.

In 1986, Congress also specified processes for identifying allowable charges that are unreasonably high or low, modifying current payments to correct for inappropriate specialty or geographic differentials, and adjusting payments to reduce imbalances in the ratios of charges to resource costs for various procedures. On the basis of inherent

reasonableness, Congress limited allowable charges for the services of ophthalmologists and anesthesiologists during cataract surgery.

In addition, Congress acted to protect beneficiaries from increased financial liability in cases where payment levels for a specific service are reduced on the basis of inherent reasonableness. A special cap now applies to actual charges of nonparticipating physicians that would bring their maximum allowable actual charge to 125 percent of the inherently reasonable charge level within two years of a determination on inherent reasonableness.

Efforts also have been made to control inappropriate use of physician services. In 1984, Medicare carriers were required to initiate prepayment screens to review claims for seven common services. That effort was expanded to sixteen services in November 1985. In addition, the review of hospital admissions by Peer Review Organizations and the financial incentives under the Prospective Payment System for hospitals to minimize Medicare patients' lengths of stay could cause physicians to eliminate certain services, thus introducing an indirect degree of volume control.

There have also been efforts to protect beneficiaries from excessive out-of-pocket costs and to increase their ability to identify physicians who accept Medicare's allowed charge as payment in full. In 1984, Congress introduced the concept of the participating physician who agrees to accept Medicare's approved charge as payment in full for the covered services provided to all Medicare patients. In 1986, a number of provisions were added to the participating physician program and to inform beneficiaries about the program and to further encourage physicians to enter agreements.

Despite these measures to slow increasing expenditures, there is a growing dissatisfaction with the CPR method of payment and a realization that these efforts are only stop-gap restraints on a fundamentally flawed payment system. Agreement on a single option to modify or replace the current system has yet to emerge, but the four general approaches described in Chapter 1 represent the range of alternatives currently under consideration.

Payments for HMOs and CMPs

Although the amounts are not now very significant, Medicare also pays physicians indirectly through its payments to HMOs and CMPs. The method of paying HMOs and CMPs is intended to provide these entities with a captitated payment equal to 95 percent of what Medicare would have paid for a beneficiary if that beneficiary had remained in the traditional Medicare program.

The payment method makes use of a calculated Average Adjusted Per Capita Cost (AAPCC) for county-based service areas. The AAPCC adjusts

for certain beneficiary characteristics (age, sex, welfare status, disability, institutionalization). Primarily because it fails to measure adequately a beneficiary's health status or need for care, the AAPCC provides a poor estimate of what Medicare would have paid for a beneficiary. If healthier beneficiaries tend to enroll disproportionately in HMOs and CMPs--and there is some evidence that this has happened--then Medicare is probably overpaying these entities and is not achieving the savings it intended. Of course, if these entities provide better coverage and quality of care, then the enrolled beneficiaries do benefit.

SUMMARY: DEMANDS FOR CHANGE

The combination of huge budget deficits and large increases in already high Medicare expenditures inevitably creates strong pressures for change in the Medicare program. These pressures prompted the significant reforms in Medicare's hospital payment methodology in 1982. These reforms have, in turn, given additional momentum to the search for improvements in methods of physician payment. As outlined in this and the preceding chapter, the major criticisms of the current program are several.

- The CPR payment methodology, like other fee-for-service methods, has encouraged fee inflation and excessive use of medical services.

- The CPR method has generated a distorted price structure that leads to inappropriate patterns of medical care and inequities among categories of physicians.

- Neither beneficiaries nor providers can readily predict Medicare payment levels; they are, therefore, unable to project easily the financial implications of their decisions.

- The entire system--the CPR method combined with its mechanisms for administration, utilization control and claims assignment--is too complex to understand and manage effectively.

- As the SMI program has evolved, the goal of beneficiary financial protection has suffered, with the greatest burdens placed on low income and seriously or chronically ill beneficiaries.

The next several chapters of this report review the Commission's initial providers was and is an important principle.

CHAPTER 3

FEE SCHEDULES

Fee schedules provide an alternative to the CPR system for setting Medicare payments for physicians' services. Setting payments through fee schedules could address several deficiencies of the current way of paying for physician services, but would leave other problems unsolved.

A fee schedule can be defined through a scale of relative values (RVS) for physician services, a conversion factor that converts relative value units to dollar values, and one or more multipliers to adjust for factors such as geographic location (Office of Technology Assessment, 1986; Congressional Budget Office, 1986; Jencks and Dobson, 1985).[1] The development of a fee schedule requires decisions about important policy issues implied by alternative designs of the fee schedule.

A schedule of fees would determine what Medicare would pay for each service. The fee schedule could be the amount Medicare would pay to the physician or patient regardless of the physician's charge (an indemnity schedule). Alternatively, it could specify the maximum amount Medicare would pay, and Medicare would pay the lesser of this amount or the amount charged.

A fee schedule determines the payment for each unit of service, but costs to beneficiaries and to the program depend also on the volume of services provided and billed. The amounts and combinations of services provided are also one determinant of the quality of care. Methods to monitor and influence the amounts of services provided must be considered for any payment system, including a fee schedule.

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[1]A relative value scale assigns weights for each service; the weights represent the relative amount to be paid for each service. For example, if the value of a hospital visit was 10 and a surgical procedure 100, then the fee for the surgical procedure would be ten times that for the visit. An RVS can be based on charges, costs, or other factors. A conversion factor gives the fee in dollars for the service units in the RVS; a conversion factor of $3 per unit means that the hospital visit with a weight of 10 would have a $30 fee. A location multiplier specifies differences in payments between geographic areas, with a value of 1 in the reference area. A location multiplier of 1.1 would increase fees in that area by ten percent--the fee for the hospital visit would be $33. In effect, the location multipliers change a single conversion factor to a set of location-specific conversion factors that vary across geographic areas.

Patterns of allowed charges under Medicare are moving slowly toward specialty- and location-specific fee schedules based on 1973 prevailing charge limits (see chapter 2). However, these fee schedules would reflect prevailing charges in 1973, with no adjustments since then for changes in medical practice, productivity, and other factors. A fee schedule developed explicitly for Medicare would incorporate different relative values that should be more appropriate for current medical practice.

The Consolidated Omnibus Budget Reconciliation Act directed the Secretary of Health and Human Services to develop and report to Congress on a relative value scale for physician payment by July 1, 1987. The Omnibus Budget Reconciliation Act of 1986 deferred the report to July 1, 1989, and set potential implementation for physician payment on or after January 1, 1990. In 1986 the Department of Health and Human Services entered a cooperative agreement with the Harvard School of Public Health to develop a scale of relative values by mid-1988.

ADVANTAGES AND DISADVANTAGES OF A FEE SCHEDULE

Paying for physicians' services on the basis of a fee schedule has several advantages over the current system. Fee for service would remain a mode of payment for physicians' services under Medicare. However, a fee schedule would decrease the complexity of the system. The inflationary stimulus attributed to basing future prevailing fees on current charges under CPR would end.[2] Developing a fee schedule would provide an opportunity to change relative payments for different services and the associated financial incentives for their use. The system could be more equitable for physicians by paying different physicians similar amounts for similar services.

A fee schedule would leave several problems unsolved. Although the specific inflationary link under CPR between current charges and future allowed charges would end, pressures to increase levels of payment in the fee schedule would remain. After implementation, physicians and others would press to increase Medicare fees, particularly to reflect fee increases under private insurance. Perhaps the most important residual problem is the need for improved mechanisms to control the volume and total cost of services.

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[2]Under CPR, a physician's future customary charges and the future prevailing charges for physicians in the area are limited by current charges. This gives physicians an incentive to increase current charges. By setting maximum payments independently of physicians' current or past charges, fee schedules eliminate this "inherently inflationary" incentive. The imposition of the MEI, which limits at least 60 percent of allowed charges independently of the customary and prevailing charge (Chapter 7), may already have reduced the inflationary stimulus described here.

The success of a fee schedule in improving Medicare physician payment will depend on its design, implementation, and how it is used. On balance, the Commission believes that a well-designed fee schedule would be superior to CPR and would have considerable potential for improving Medicare's physician payment method in the next few years.

> **RECOMMENDATION: The Commission endorses the concept of a fee schedule for paying for physicians' services to Medicare beneficiaries. The relative payments for services, locations, settings, and perhaps specialties, would differ from the patterns of allowed charges under the current system. A recommendation that Medicare adopt a fee schedule, or specific characteristics or a specific development process, will require decisions on issues of design and development that the Commission has not yet had the opportunity to examine.**

The endorsement of a fee schedule for Medicare would not preclude the adoption of other methods of paying for physicians' services either, in addition to or in place of fee for service. The Commission will study alternative methods of physician payment.

Fee-for-Service Payment

Retaining fee for service has several advantages. It is the predominant form of payment for physicians' services in the United States, and its strengths and weaknesses are known through experience; both physicians and beneficiaries are familiar with the current system. A modified fee for service payment system would be more easily accepted by physicians and perhaps by beneficiaries than a more extensive change. Little new administrative machinery would have to be developed.

Fee for service allows payment to reflect accurately the volume and mix of services provided to each patient. Methods that base payment on larger packages of services, such as all physician services during a hospital stay, cannot as easily adjust payment for variations in complexity of care for different patients.

A modified fee-for-service system might serve as a transitional stage in a move to another payment system. For example, a fee schedule would provide a basis for calibrating payment for packages of services or capitation.

Simpler System

With a fee schedule, all physicians in a geographic area would have the same schedule of allowable charges or maximum payments.[3] The reduced variation in allowable charges should make the system easier for physicians and beneficiaries to understand. Out-of-pocket costs to beneficiaries and revenues of physicians should be more predictable.

Each physician's fee schedule could be calculated from an RVS and an area conversion factor. Carriers would no longer have to calculate a prevailing schedule for each group of physicians in each area, or a unique customary fee screen for each physician.

Improved Incentives

Under CPR, some services are reimbursed more generously relative to costs than other services. This gives physicians an incentive to provide more of the highly profitable procedures than is medically most appropriate, though there is little evidence to determine how often this happens. The resulting differences in financial returns may also provide inappropriate financial incentives affecting their decisions as to where to practice and whether to specialize.

A fee schedule could change relative payments for services and the associated incentives and potentially improve the effectiveness of medical practice. A fee schedule with payments more in line with costs would reduce the financial incentive to provide one service over another, leaving the choice of services to be determined by physicians' medical judgment and patients' preferences.

Similarly, the charges allowed by Medicare are thought to be higher relative to costs in some geographical areas than in others, providing a financial incentive to physicians to locate in those areas.[4]

A fee schedule with fees more in line with relative costs would change these incentives, perhaps leading to more equal access to physicians' services.

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[3]If multipliers for other purposes besides location were used, then additional subgroups of physicians or services would be defined, and additional calculations would be required.

[4]There are many influences on physicians' decisions to locate and specialize besides relative expected financial returns. Location is influenced by their preferences for different settings for living, by spouses' preferences and opportunities for work, and so forth. Similarly, choice of specialty depends on nonfinancial factors. It is not clear how much changing financial incentives will change these decisions. However, competition among physicians may increase the importance of financial factors in the future.

Physicians of different specialties perform some services unique to the specialty, and some that are similar across specialties, such as visits. The financial returns to some specialists are generally higher than to other specialists--particularly those who provide mostly primary care--and to generalists. These differences could influence physicians' choice of specialty training, perhaps leading to too many physicians in some specialties relative to others. A fee schedule could reduce the financial incentives to train for one specialty over another, and might lead to a more appropriate distribution of physicians among specialties. This is a complex problem, however; it is not clear how many physicians of each specialty will be needed in the future.

Unsolved Problems

Fee schedules would not address all problems of the present system. The most prominent remaining tasks relate to the need to constrain growth in the volume of services and costs of the Medicare program. Overall price levels may not increase less rapidly than under CPR, and increased volume of services could also increase total expenditures.

Many assume that implementation of a fee schedule would be budget neutral: increases in fees for some services would be offset by decreases in others. This must be done with care. If some of the new fees set by Medicare were markedly lower than those paid by private insurers, beneficiaries might find it difficult to obtain those services or would have to pay a large amount out of pocket. However, adoption of a fee schedule by Medicare may influence what other payers will offer, so the effects of setting Medicare fees different from present levels are hard to predict.

When the fee schedule is implemented, physicians who had been charging less than the limits specified by the new fee schedule might increase their charges to those limits. After the fee schedule has been in place for some time, there will be pressure to increase payment for specific services and the overall level of payment. The strength of this pressure will depend in part on changes in payment by other payers and on competition among physicians.

The relationship between fee levels set by Medicare, payment levels from private insurers, and access for Medicare beneficiaries must be monitored and appropriate changes made in the Medicare fees.

Volume of Services

A fee schedule would rationalize the physician's relative financial incentives to provide one service instead of another. This may reduce the use of services that were previously overpaid, improve the mix of services provided to patients, and increase the efficiency and effectiveness of care. However, under any system paying fee for service,

there remains a financial incentive for the physician to provide all services for which there is an expectation of even a marginal benefit to the patient. Patients (and physicians when acting on their behalf) have similar incentives, balanced against their own costs. This may lead to a high volume of services and costs to Medicare with little or no additional benefit to patients. Within the context of limited budgets for health services, expenditures on services of marginal benefit may reduce funds available for other health care needs.

DEVELOPMENT AND IMPLEMENTATION

Developing and implementing a fee schedule requires a number of decisions with policy implications. This discussion assumes that fee schedules will be developed from a scale of relative values and a conversion factor modified by a multiplier for location and perhaps other factors. A single set of procedure codes, uniformly applied, would be required. Alternative bases for a relative value scale and multipliers and alternative processes for specifying an RVS and multipliers are discussed. How payments are based on the fee schedule (for example, if Medicare pays the lesser of the physician's charge or the fee amount) and restrictions on physicians' actual charges must be determined.

Coding

To realize the full benefits of a fee schedule would require that the same set of codes be used throughout the country, the set of services represented by each code be uniformly defined, and the same service be reported consistently in all areas. This would help ensure that comparable payment would be made for comparable services.

Medicare has made substantial strides toward uniformity of coding with the development and use of the HCFA Common Procedure Coding System, but further work is needed. The recommendations discussed in chapter 9 would move Medicare further toward the coding system required for a fee schedule.

Developing Relative Value Scales and Multipliers

A fee schedule could be based on relative charges, relative costs, relative "value", market information, or a combination of these. Most attention has focused on several approaches to cost- or resource-based relative value scales. However, these issues require further study. Each approach has advantages and disadvantages. It is likely that a fee schedule for Medicare would be based on a combination of several elements.

Charges. A relative value scale could be developed readily from data on physicians' actual or allowed charges. Juba and Hadley (1985) have discussed the properties of several RVSs developed from charges. But such a scale would preserve the relative financial incentives in the current structure of allowed charges, and the Commission does not wish

to institutionalize current relative values. It sees little merit in RVSs or fee schedules based solely on historical Medicare prevailing charges.

This would not preclude the use of some of the information in current charge patterns in the development of the RVS. For instance, Hadley and Berenson (1986) have suggested that current charges could form the starting point from which an RVS would be developed. Cost-based relative values within closely related groups of procedures may not differ from the relative values implicit in charge patterns. Within these groups of procedures, charges may provide information useful in developing relative value scales.

Costs. An RVS based on relative costs of production would tend to reduce the influence of financial incentives on choice of services for each patient. Equalizing the financial returns from different services would also make the payment system more equitable. Basing an RVS on measured costs of production also provides an element of objectivity.

The cost of production of each physician service is made up of overhead expenses, the costs of a physician's substitutes and extenders, and a physician's time and effort. The components of the overhead expenses of practice--malpractice insurance, rent for office space, compensation of nurses and other office personnel, and so forth--can be measured objectively. Suitable indexes of costs of practice are not now available but could be developed.[5]

The single largest component of the costs of production for physicians' services is the value of the physician's own input. Determining the value or cost of the physician's time and effort is difficult. The average time required to provide each service could be measured objectively. For example, some information on the time spent by surgeons and anesthesiologists can be determined from operating room records.[6] Surveys of physicians or less formal judgments of physician panels could be used to estimate time (Egdahl, 1985; Hadley and Berenson, 1986; Hsiao, 1986). More exacting measurements of time required for various services,

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[5]The Medicare Economic Index (MEI) was constructed to measure changes in these overhead expenses over time, but is not detailed enough to use as the basis for a fee schedule. Congress in the Omnibus Budget Reconciliation Act of 1986 directed the Secretary of HHS to develop an index to reflect geographic variations in practice costs; an interim index is to be developed by January 1988 and a refined index by December 31, 1989.

[6]The time spent in the operating room is only one component of the service provided by the surgeon or anesthesiologist. Time spent before the operation and in monitoring recovery and followup of the patient also must be included.

using techniques such as microcosting or time and motion studies, would be prohibitively expensive (Wagner, 1983).

Time alone does not reflect the total of the physician's contribution. There are differences in the intensity of mental and physical effort, judgment and skill required, stress to the physician because of the risk of the procedure to the patient, and other factors that may be appropriate bases for differences in payment. These other factors can be grouped together as the "complexity" of physicians' time.[7] It is thought that more complex time costs more (or that it is appropriate to pay more for it) because it is "worth" more, or that such services have to be more highly remunerated in order to induce physicians to provide an adequate supply of them (Reinhardt, 1984).

The complexity of the time for each service is in part subjective and cannot be measured directly. The relative complexity of time for each service could be based on the collective judgments of a large number of physicians through interview or survey techniques, consensus of a smaller number of physicians and others, or a combination of these methods (Hsiao, 1979, 1986; Hadley and Berenson, 1986; Egdahl, 1985).

The information generated by these techniques can be combined into a relative value scale based on the "costs" of physician services: measurement and estimation of overhead costs, and of time; and determination of complexity by survey or consensus of opinion. Different ways of combining the components lead to relative value scales with different relative weights.

Under CPR, charges for services of specialists are generally higher than services from less specialized physicians. Physicians increase their knowledge and develop special skills through advanced training. The costs of additional training needed to perform a specialized procedure may be an appropriate basis for differences in fees. If relative charges for different services just accounted for differences in the cost of training needed to perform them, the fee schedule would provide no financial incentives for pursuing additional training in one area over another.

It is not clear how the costs of specialized training should be incorporated into a cost-based RVS. Most of the costs of specialized training may already be accounted for in the relative values for specialty-

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[7]"Complexity" has been used and implicitly defined by several investigators. Its use here does not imply acceptance of any particular definition, but rather represents an unspecified set of factors that influence the value of each unit of time spent providing services. Many of those factors are discussed in the text.

specific services through higher complexity.[8] If increases in relative value of specialty-specific procedures do not fully account for differences in costs of training, fees could differ among specialists for other services such as visits. A specialty differential might apply only to those services for which each specialist's advanced training is expected to increase the quality of the service.[9]

The issues involved in specifying fees for services of specialists are complex. Other factors besides costs could be considered. For instance, cost-based specialty differences in fees may lead to surpluses or shortages of specialists or the services they provide, particularly if such fees differ markedly from those paid by other third party payers.

Other Factors. While a fee schedule based on costs has desirable properties, it has been argued that other factors besides cost of production determine the value of a service to Medicare beneficiaries and to society, and that these factors should be considered in determining what Medicare should pay for the service (Office of Technology Assessment, 1986; see also chapter 5). For example, it has been argued that criteria for setting relative fees should also include risks and benefits to patients, efficacy of the procedure, and costs and benefits to society (Hadley and Berenson, 1986, 1987).

A fee schedule reflecting costs alone would in theory be incentive-neutral to physicians. However, payment for some services might be set higher than the cost-based level to encourage the use of those services. For instance, if preventive services have special value to society in addition to the value to the patient, increasing the payment to physicians for providing those services might have the result that beneficiaries receive more preventive services, with concomitant benefits for society.

Market Mechanisms and Indicators. In a well-behaved competitive market, prices rise for services in short supply and fall for services in surplus. The market for physicians' services is not a well-behaved

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[8]Each specialist provides some services unique to that specialty. For instance, cataract operations are performed only by ophthalmologists. Other services are provided by physicians of several specialties, with different amounts and kinds of training. For a cost-based RVS, the relative value of each service would be set to account for the complexity of the service--the effort, judgment, and skill required to perform the service. Since the specialized skill and judgment employed is acquired through advanced training, increasing the relative value for complexity may already account for the costs of the specialized training. Adding another factor for training costs may amount to double counting.

[9]Consensus panels of physicians could determine which services should carry such a differential and what physician training should be required to receive the higher payment.

competitive market, and allowed charges set through CPR do not represent competitive market prices. Nevertheless, information about prices, shortages, and surpluses may be useful in developing and updating a fee schedule.

If a fee schedule were implemented, some fees might turn out to be higher or lower than needed to provide access to good quality care for Medicare beneficiaries. If Medicare were to set the fee for a service too low--for instance, a service in short supply where the fee is below what others are paying--Medicare beneficiaries might have to pay a large balance bill to obtain the service or be denied access to some physicians if balance billing is prohibited.[10]

Information on excess supply or shortages for services might be taken into account in developing a fee schedule to avoid or correct such problems. If shortages of a service are anticipated at the payment level proposed for the fee schedule, or develop after the fee schedule is implemented, that fee could be increased. Similarly, evidence that a service is in excess supply might lead Medicare to lower a fee, particularly where Medicare is a dominant purchaser.

However, information on shortages and excesses is not readily available. It has been suggested that high assignment rates may indicate ample supply of services and low assignment rates a shortage.[11] However, assignment rates may be poor indicators of market conditions: much of the variation in assignment rates is caused by other factors. A second possible indicator might be based on comparisons of what Medicare pays to what others pay. Since other purchasers are competing with Medicare beneficiaries for physicians' services, prices charged to other payers suggest what Medicare could pay while maintaining access to services.

It has been proposed that Medicare use market mechanisms directly to set levels of Medicare payments. Under a fee schedule, competitive bidding

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[10]This does not mean that Medicare could not set fees lower than it and other payers are now paying. Implementation of a fee schedule by Medicare might lead other payers to change the methods or amounts they pay for some physician services.

[11]The idea is as follows. If Medicare beneficiaries tend to seek physicians who accept assignment or participate, and physicians accept assignment or participate to compete for patients, then high rates of participation and assignment for a service or in an area may indicate that competitive pressures among physicians are strong and physician services are plentiful. Allowable charges could be reduced in such cases without significantly reducing access to physicians or increasing the financial burdens of beneficiaries. Conversely, areas with low rates of assignment and participation would suggest scarcity of physician services where allowed charges should be increased.

might be used to set conversion factors for individual physicians or for all physicians in an area (Jencks and Dobson, 1985; Office of Technology Assessment, 1986; Hadley and Berenson, 1986, 1987). The use of competitive methods to set the value of services, including competitive bidding, might allow Medicare to take advantage of its considerable purchasing power to increase access to services. But methods suggested for setting prices (relative values or conversion factors) on the basis of market indicators are not yet tested. Other proposals to take advantage of market forces could also be considered, including "most favored payer" policies (Jencks and Dobson, 1985) and PPOs sponsored by Medicare.

Conversion Factors and Multipliers

Conversion factors and multipliers must be specified to calculate the fee schedule for each group of physicians' services. A conversion factor would convert relative values to payments in dollars. The conversion factor might be set by legislation and regulation, by explicit negotiation involving physicians and other parties, or by a commission.

For a given volume of services, the conversion factor would determine total expenditures on physician services; conversion factors could be set to achieve an expenditure target. However, the volume of services is not fixed and might change in response to changes in fees. The growth of program expenditures also will depend on the effectiveness of measures to influence the volume of services.

A location multiplier could vary among regions, states, or carrier areas; it could differentiate among frontier, rural, central city, and other urban locations. As noted in chapter 4, costs of practice vary among geographic locations. If differences in allowed charges among different locations accounted only for differences in the cost of producing services, the fee schedule would not provide financial incentives for physicians to locate in one geographic area instead of another. Such a fee schedule would also treat physicians in different locations more equitably because they would receive similar payment for similar work after adjusting for differences in overhead expenses.

Consensus Processes

Each of the approaches suggested for development of a fee schedule relies in part on the assessment of "informed opinion," particularly for addressing more subjective questions such as relative complexity of services or "value" of services. A number of methods are available to collect and aggregate such information, including surveys, interviews, or group decisionmaking processes. In addition to the choice of method and the persons chosen to participate, other decisions must be made in structuring these processes (Berenson, 1983; Fink et al, 1984).

Those participating, either as consultants or as group members, must collectively provide expert knowledge and represent the positions of

interested parties and the interests of society. For some tasks, such as the estimation of time and complexity of various procedures, the contribution of expert physicians would be especially important. For tasks such as adjusting relative values to reflect factors other than costs, representatives of other interested parties (beneficiaries, government, insurers, etc.) and experts in health policy would be important.

A number of processes have been developed for group decisionmaking, including the Delphi, modified Delphi, and nominal group techniques. Specific examples of group decision processes used in medicine include the consensus development conferences of the National Institutes of Health, the Dahlem conferences, and the methods used by the Graduate Medical Education National Advisory Panel to estimate numbers and types of physicians needed for the future. Optimal size and composition of the groups, as well as the process to be used, would depend on the task.

Negotiated Fee Schedules

In several Western countries, fee schedules are set through an overtly political process such as negotiation with physicians. In Canada, for example, medical societies from each province represent physicians in negotiations with each provincial government. The process covers all aspects of the fee schedule--relative value scales, multipliers, and conversion factors.

A directly analogous process may not be feasible in the United States. For instance, it is not clear that there is any one body that could negotiate for all physicians. Also, because Medicare pays for services for only part of the population, negotiation may be less effective. Nevertheless, any new system of physician payment, including fee schedules, will be developed with political as well as expert technical input by physicians and other groups. A fee schedule could be developed under the auspices of HCFA, with guidance from the Commission and the Congress. Alternatively, Congress could ask the Commission to supervise the preparation of a fee schedule. Whatever the process, physicians, beneficiaries, and other interested parties would participate at several levels and provide input based on social and political values as well as technical expertise. It is incumbent upon those responsible for the development of fee schedules to provide appropriate channels for that input.

Updating the Fee Schedule

A fee schedule would have to be updated over time: new services added, relative values and multipliers changed. An RVS would be expected to change slowly to account for changes in medical practice. The conversion factor could change more frequently in response to changing prices for physician services, budget constraints, beneficiary demands, or perceived effects on beneficiary access and financial liability. Explicitly

or implicitly, updates in conversion factors are likely to depend on changes in volume of services.

Changes could be made in a mechanical way. For example, the conversion factor could be tied to an index such as the MEI. Alternatively, the processes used to change an RVS and multipliers could be similar to those used to establish them.

The Physician Payment Review Commission might be charged to participate in updating the fee schedule. Under the prospective payment system that Medicare uses to pay hospitals, the analogous tasks of updating the diagnosis related group weights and setting the overall payment level are undertaken by the Congress with advice from the Prospective Payment Assessment Commission.

Constraining Use of Services

The volume and total cost of physician services have grown rapidly during the past several years despite freezes on charges allowed by Medicare. A fee schedule, in common with CPR and other fee-for-service payment methods, lacks financial incentives for physicians to limit the amount of services provided to patients. A payment system based on a fee schedule needs to include mechanisms to control the provision of services, particularly those that are not medically necessary. The challenge is to find methods that effectively reduce inappropriate services without cutting into needed services as well.

Medicare now employs a variety of utilization review tools intended to reduce unnecessary services. Although Peer Review Organizations were established primarily to support management of cost of Part A services, the review of hospital services entails review of inpatient physician services. Part B carriers also evaluate the medical necessity of physicians' services. The methods used by PROs, carriers, and private payers provide a foundation for controlling the use of services under a fee schedule, but better methods are needed. Clinical research on the determinants of quality of care and development of standards of appropriate utilization for specific medical conditions could increase the effectiveness of measures to ensure that services are used in the most appropriate manner.

Medicare could also attempt to limit expenditures on physician services through nonspecific caps on total expenditures or areawide budgets (Etheredge, 1986). A cap on expenditures could reduce the fee paid for each service when total expenditures in an area exceeded a target. However, such a system would reduce payment for both necessary and unnecessary services. It is not clear how effective these methods are.

The Commission will undertake an assessment of methods of controlling utilization, particularly those that may selectively reduce nonessential services, and a review of research and development in this field.

Assignment Policy

Assignment policy must be considered in the development and implementation of a fee schedule. When a fee schedule is implemented, the prices paid by Medicare will change; some will fall significantly. The Commission shares Congress's concern that lowering the amount paid could restrict the access of beneficiaries to those services, either because physicians will not provide the service for the Medicare fee under assignment or because the beneficiary cannot afford the difference between the physician's charge and the price Medicare will pay if balance billing is allowed. These difficult issues are discussed more fully in chapter 6.

Implementation

Once a new schedule of allowable fees is determined, implementation in stages would allow for adjustments to be made. The effects of changes in payments to physicians should be monitored carefully.

Staged implementation would reduce the size of financial gains and losses for physicians, changes in the financial liability of beneficiaries, and the threat to access and quality of care. For instance, charges allowed during a transition period could be a blend between established allowed charges and those implied by the fee schedule. Allowing change to occur gradually could increase physicians' acceptance of the new payment system and their cooperation. The transition process could, however, place significant burdens on carriers. Careful planning of the implementation would increase the chances of success.

Whatever the nature of a new schedule of allowable fees and its implementation, the quantity of services provided, access to care, and the quality of care should be monitored to assess the results of the program and to provide a basis for further change.

WORK PLAN

During the next year, the Commission will begin to study the issues involved in designing, developing, and implementing fee schedules, and will recommend a particular course of action. Those issues and tasks include

- the basis of a relative value scale and multipliers--charges, costs, "value", market indicators--and bases for differences in fees including location and specialty;

- the processes of developing a relative value scale and multipliers--studies of costs or charges, consensus processes and expert panels, and negotiations;

- how the fee schedule could be used to determine payments to the physician or patient;
- the method for changing the relative value scales, multipliers, and conversion factors over time;
- assignment policy;
- the nature of the transition from the present system of payment to a system based on fee schedules, and methods of monitoring the effects of the new system during and after the transition period;
- the administrative feasibility of alternative approaches;
- the acceptability of alternative designs to physicians and beneficiaries; and
- methods to limit the use of unnecessary services and to control total program expenditures.

The Commission will examine fee schedules currently used in the United States and other countries and the methods used to develop them, and efforts now under way to develop scales of relative values and fee schedules not based on charges. Relative values for various physician services under other fee schedules will be compared to the implicit relative values under CPR.

The Commission intends to simulate, using Medicare data, the effects of alternative fee schedules with different scales of relative values. Such simulations will help predict the effects of a new system.

CHAPTER 4

GEOGRAPHIC VARIATION IN CHARGES

Even though the supply of physicians has grown substantially in recent decades, there remain rural counties, towns and sections of major metropolitan areas with no physician. In other areas, physicians must work extraordinary hours to meet residents' basic medical needs. The Commission is concerned that residents of some rural and urban areas have only limited access to medical care, and that Medicare policies may make some contribution to this problem.

Several factors account for geographical shortages of physicians. They include the limited purchasing power of local residents, the absence of modern medical facilities, and the difficulties in finding suitable work for nonphysician spouses. Limits on potential income from practice, partly attributable to a tradition of low charges and low third-party payment rates, may be another factor.

BACKGROUND

Medicare payment rates for physician services do tend to be higher in metropolitan than in rural areas. Burney et al. (1978) reported prevailing charges in metropolitan counties nationwide to be 23 percent higher than in nonmetropolitan counties, on average. However, they noted also that these differences were not uniform. In Illinois and New York, for example, charges in metropolitan areas exceeded those in nonmetropolitan areas by at least 28 percent, whereas in Rhode Island and Connecticut, prevailing charges in nonmetropolitan counties exceeded those in metropolitan areas.

More generally, researchers have documented extensive variation by geographic area in Medicare prevailing charges. Among Medicare's 240 charge areas, three- and four fold differences in charges for particular procedures are common (Office of Technology Assessment, 1986; Burney et al., 1978). Even within a state, charges vary widely from area to area. In Texas, a large state with many charge areas, the highest prevailing charge for a general practitioner's follow up hospital visit in 1984 was approximately 2.5 times greater than the lowest (U.S. Department of Health and Human Services, 1984.)

Determinants of Variation

Some studies have examined the relationships between physicians' charges and explanatory factors such as costs of living, the cost of equipment and labor, income per capita, and demographic characteristics of physicians

and patients. Much of the geographic variation in charges remains unexplained even after controlling for those factors.

Adjusting charges for regional differences in costs of living eliminates some of the geographic variation. One study reported that Medicare prevailing charges in the largest metropolitan areas were 35 percent above the national average; those in the smallest rural counties were 18 percent below. Adjusting for costs of living reduced those differences by about half (U.S. House of Representatives, Committee on Ways and Means, 1980).

Geographic variation in costs of practice has not been examined extensively because of limitations in data. One study found that variation in wages paid to office employees was an important determinant of variation in fees, but the effects of other variables, such as patients' age and incomes, insurance reimbursement mechanisms, and physicians' credentials, were weaker or inconsistent (Steinwald and Sloan, 1974). A study of variation in surgical fees found that region of the country and size of the metropolitan area were more important determinants of variation than factors such as physicians and hospital beds per capita, income per capita, and the fraction of elderly in the population (Dyckman, 1978). The persistent significance of city size and region in the study indicates that other, unmeasured factors associated with those variables are important determinants of surgical fees.

Policy Issues

Drawing upon these and other findings, Medicare policymakers have begun to question the appropriateness of paying physicians different amounts in different areas for nominally the same service. Two concerns are paramount. The first and most important is that enrollees' access to care may be harmed; the second is that payments among physicians may be inequitable.

The Commission is concerned that low Medicare approved charges and payments in some areas may jeopardize enrollees' access to care. In the short run, physicians' willingness to accept assignment of Medicare claims may be compromised if approved charges are especially low in relation to the costs of practice. In the long run, low approved charges can reduce access to care by affecting physicians' decisions to establish and maintain practices. Unfortunately, the current pattern of geographic variation has persisted for a sufficiently long time that these long run effects may be with us today.

In addition, the current payment system is inequitable in that physicians with comparable training and experience can receive substantially different payments for providing the same service, a pattern that persists even after accounting for cost-of-practice or cost-of-living differences. This inequity is exacerbated when across-the-board reductions in payment constrain all physicians' fees, high and low alike.

RECOMMENDATION: As an initial step to deal with geographic variation, the Commission recommends that Medicare pay an increment beyond approved charges for primary care services delivered in designated underserved areas. These additional incremental payments would not affect coinsurance amounts and could be financed by a slight reduction in the MEI update factor.

Should such this recommended step be taken, such details as the definition of underserved areas and the size of the increment would have to be addressed. Currently, the Public Health Service maintains two definitions of underserved areas--medically underserved areas and health manpower shortage areas. Since the recommendation would not involve calculating prevailing charges, the fact that these areas do not correspond to carrier charge areas does not preclude them from consideration.

The size of the increment would depend both on the restrictiveness of the definition of services eligible for an additional payment and the willingness to decrease the MEI update factor to generate funds for it. As a rule of thumb, each 0.1 percentage point reduction in the update factor would yield $10 million.

The recommended change would bring consistency to Federal policy on increasing access to physician services in underserved areas. Congress has established a number of programs, such as the National Health Services Corps, to expand supplies of physicians in underserved areas. At the same time, Medicare constraints on physician payments, such as the MEI and the 1984 fee freeze, have applied across the board to physicians in all areas of the country. These policies appear to work in opposite directions. The proposed increase in payments for services provided in underserved areas would take a step towards redressing this inconsistency.

Beyond this recommendation, the Commission expects that additional steps to address geographic variation will be warranted. However, careful analysis is required before proceeding further. As discussed below in the workplan, the Commission will study the geographic patterns of Medicare charges and payments and review the existing research on the relationship between payment levels and physician location decisions. The Commission will then make a comprehensive assessment of policy affecting geographic variation in Medicare charges.

WORKPLAN

As feasible within budget and time constraints, the Commission plans to conduct extensive analyses of Medicare data files:

- o to define the magnitude and extent of geographic variation in Medicare prevailing charges and service frequencies, adjusted for differences in practice costs and other economic factors;

- o to predict the likely outcomes of policies to change geographic patterns in Medicare charges. Special attention will be given to the effects of each policy option on total Medicare program payments and beneficiaries' liabilities in urban and rural areas; and

- o to assess the effect of proposed changes in payments on physicians' willingness to accept assignment.

Analyzing Variation in Charges

Analysis of geographic variation in physicians' Medicare charges will require construction of charge indexes for a constant marketbasket of procedures in different areas across the country. Indexes of Medicare charges for high-frequency procedures will be appropriately deflated for costs of living and costs of practice, as feasible.

At present, no widely accepted deflator for practice costs exists. The Commission will investigate the availability of data on the constituent elements of practice costs (principally nurses' wages, office ownership or rental costs, malpractice insurance, and supplies) and assess the feasibility of deflating Medicare charge indexes. The requirements for a deflator used in analytic work are less stringent than requirements for a payment deflator; the Commission hopes to develop a useful version of the former deflator and a workplan for developing the latter. Later in the development process, physicians and other interested parties will be asked to review the charge indexes and cost deflators for appropriateness and reasonableness.

In the Omnibus Budget Reconciliation Act of 1986, Congress requested the Secretary of Health and Human Services to develop an index of geographic variation in physician practice costs. During its own investigation of practice cost indexes, the Commission will monitor that study to ensure that it is not duplicating the efforts of HHS.

Economic factors other than practice and living costs might also contribute to the geographic variation in Medicare charges. If so, adjusting charges to account for those factors might be appropriate. To study this, the Commission will analyze the relationship between geographic variation in Medicare charges, cost of living, cost of practice, and other variables, including availability of physician and hospital services and demographic characteristics of local populations.

Analysis of Service Volume

The amount or volume of physician services that Medicare beneficiaries obtain at approved charge levels is one measure of access to care. Data permitting, the Commission will investigate the extent of geographic variation in the use of physician services by Medicare enrollees and the relationship between that use of care and such variables as local charge levels and supplies of physicians.

Practice Location Decisions

Access to adequate medical care in underserved areas is determined in large part by the availability of physicians in those areas. Knowledge of the factors contributing to physicians' decisions on the location of their practices is important for making recommendations for improving access to care by increasing physician supplies in those areas.

The Commission will review the literature on physicians' decisions on the locality of their practices, giving special attention to the relationship between Medicare and other insurers' payment rates and physicians' willingness to set up and maintain practices in particular areas. This evaluation should improve understanding of these decision processes and will guide the specification of future analysis plans.

Simulating Policy Options

As part of the process of studying policies to address geographic variation in Medicare charges and payments, the Commission will examine the results of simulations of alternative policies. One simulation, for example, might test the effects of setting local ceilings and floors on Medicare prevailing charges pegged to national or regional averages. Another simulation could test the consequences of combining fee areas within states where multiple areas now exist.

Among the questions such simulations might answer are: would total program payments for services provided in underserved areas increase or decrease? Would physicians in different specialties be affected differently by that policy? Would the proposed action have different effects on practice income, beneficiary liability, and Medicare payments in different areas of the country?

CHAPTER 5

INHERENT REASONABLENESS

Congress has specified a process to identify services with allowed charges that are out of line with other charges, to increase or decrease those allowed charges, and to place limits on actual charges for services for which allowed charges are decreased.

BACKGROUND

The Consolidated Omnibus Budget Reconciliation Act of 1985 required the Secretary of the Department of Health and Human Services to promulgate regulations specifying criteria to determine inherent reasonableness. These regulations were published in August 1986 (Federal Register, 1986a). Regulations applying the criteria to allowable charges for cataract surgery (Federal Register, 1986b) and anesthesia charges during cataract surgery (Federal Register, 1986c) were subsequently published.

Each of these regulations was superceded by the Omnibus Budget Reconciliation Act of 1986, in which Congress specified an approach to inherent reasonableness, specified limits on actual charges when allowable charges are limited through inherent reasonableness, and set inherently reasonable limits on allowable charges and limits on actual charges for cataract surgery and associated anesthesia services.

The concept underlying inherent reasonableness is similar to that proposed to develop a relative value scale based on costs and other factors, but it is applied to a single service or to closely related services: comparison of allowable charges for a single service or comparable services among payers or locations (adjusted for costs of practice), or comparison of allowable charges over time for a service, adjusting for inflation and changes in resource costs and technology. Inherent reasonableness can be seen as a method of initiating changes in relative values that would occur more comprehensively and systematically through the development of a fee schedule. If so, careful and able application of inherent reasonableness would represent short-term steps consistent with longer-term goals.

Inherent reasonableness can also be viewed as a way to achieve budget goals for Medicare Part B through reductions in selected physicians' charges rather than through less selective measures such as across the board fee freezes. The Commission finds that relative payments are distorted under CPR. Selective changes in allowed charges through the process of inherent reasonableness, if carefully applied, are preferred to nonselective measures for achieving budget savings.

APPROACH TO INHERENT REASONABLENESS

The Omnibus Budget Reconciliation Act of 1986 specified a set of situations or conditions that suggest a charge is likely to fail a test of inherent reasonableness (U.S. Congress, 1986):

- "the prevailing charge for a service in a particular locality is significantly in excess of, or below, the prevailing charge for the same service in other comparable localities taking into account the relative costs of furnishing the service";
- "Medicare and Medicaid are the sole or primary sources of payment for the service";
- "the marketplace for the service is not truly competitive";
- "there have been increases in charges for a service that cannot be explained by inflation or technology";
- "the charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs"; and
- "the prevailing charge[s] for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality."

The legislation also specified a set of comparisons of resource costs or charges that would provide a justification for an adjustment in payment under inherent reasonableness. These comparisons would identify allowed charges that are out of line or unreasonable compared with charges for the same procedure in other places, charges for similar procedures, or charges for the same procedure over time after adjusting for differences in costs of providing the procedure or service. Congress defined resource costs to include "factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure." Congress directed the Secretary of HHS to review payments for ten of the most costly procedures covered under Part B.

In determining whether to adjust payment rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the likely effects on assignment rates, reductions in reasonable charges on unassigned claims, and participation rates of physicians. While the legislation provides for adjustments under inherent reasonableness to be made through regulation, HHS may also propose statutory changes to Congress.

The Commission is required to comment on all proposed regulations to implement inherent reasonableness, and the Secretary is required to respond to those comments.

Limits on Actual Charges

To maintain financial protection for beneficiaries, Congress limited actual charges of nonparticipating physicians for those procedures for which prevailing charges are reduced on the basis of inherent reasonableness. The limit on an actual charge is 125 percent of the new prevailing charge.

Charge Limits for Cataract Surgery

In the Omnibus Budget Reconciliation Act of 1986, Congress specified inherently reasonable limits on allowed charges for cataract surgery and for anesthesia during cataract surgery. All allowed charges for cataract surgery are to be reduced by 10 percent for 1987, and an additional 2 percent in 1988, though no allowed charge limit is to fall below 75 percent of the weighted national average of prevailing charge amounts. Actual charges were limited as described above. These actions followed efforts by the Secretary of HHS to impose similar limits through regulation (*Federal Register*, 1986a, 1986b, 1986c).

IMPLEMENTATION OF INHERENT REASONABLENESS PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

The regulatory process specified by Congress for applying the criteria of inherent reasonableness is difficult to execute, and may limit use of inherent reasonableness. If the goals implied by inherent reasonableness are to be reached, alternative approaches to its use must be considered. However, it appears that the intent of Congress in establishing these guidelines was to ensure that departure from the current pricing system would be based on a sound methodology and process.

Empirical Basis: Studies

Studies by the Health Care Financing Administration before the enactment of Omnibus Budget Reconciliation Act provide an indication of the difficulties involved in following this process. As specified in the Act, inherent reasonableness requires that changes in allowed charges be based on studies of relative costs. The kinds of studies that might provide an empirical basis for determinations of inherent reasonableness under the Act are illustrated by those done by HCFA for lens-extraction surgery and associated anesthesia services. These studies are described in the *Federal Register* (1986b, 1986c).

Such studies require extensive review of medical records and are time consuming and expensive. They are made more difficult by variations in

coding over time and among carriers and providers, and by the difficulty of obtaining data from past years. Comparisons over time are also complicated by changes in technology, as in the case of pacemakers and their implantation. At present there is no good index of costs of practice in various locations.[1] The studies described in the *Federal Register* (1986b, 1986c) have been criticized by affected groups as inadequate in scope and methodologically unsound. This assessment was based on partial information, since the studies have not been made available to the public.

These studies are difficult, expensive, and perhaps impossible to do to the satisfaction of some observers. It may be difficult to apply the criteria for inherent reasonableness and conduct appropriate studies to support proposed regulations for more than a few procedures. If the goals of inherent reasonableness are to be reached, it may be necessary to find alternative means to make the adjustments.

Alternative Approaches

Alternative approaches to inherent reasonableness could retain the same basis for judging charges to lack inherent reasonableness that is specified in the Omnibus Budget Reconciliation Act of 1986, but apply these criteria through a different process.

The spirit of the Act could be preserved--adjustments to allowed charges could be based on estimates of relative charges and relative costs--but a consensus process could be employed to make estimates of relative costs and appropriate adjustments of allowed charges based on them, with or without the input of studies from HCFA or other parties. In the absence of perfect information on relative costs upon which to determine inherent reasonableness, expert judgment of physicians and others could be used to supplement imperfect or absent data and generate estimates of relative costs.

Consensus processes have been proposed for developing relative cost scales, relative value scales, and fee schedules (Egdahl, 1985; Hadley and Berenson, 1986, 1987; Hsiao, 1986). Chapter 3 of this report discusses issues that must be addressed if consensus processes are to be used to develop fee schedules. Similar tasks are required for use in applying inherent reasonableness. These include choosing a process, deciding what the roles of experts should be, determining who will participate, which organizations will be represented, and how the process will be supervised. The process could be carried out under the auspices of the Physician Payment Review Commission.

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[1]Congress has directed the Secretary to develop an index of costs of practice.

The findings resulting from this consensus process could form the basis of recommendations to Congress, or perhaps the basis of the Commission's responses to inherent reasonableness regulations proposed by the Secretary.

The Commission will evaluate the extent to which consensus processes can be used to develop fee schedules for Medicare (chapter 3). Since inherent reasonableness can be viewed as an interim and partial approach to fee schedules for Medicare, approaching the task through consensus processes would provide experience useful in determining whether and how similar processes could be used to develop fee schedules.

RECOMMENDATION: The Commission endorses the goals of inherent reasonableness

- **to redress distortions in allowed charges that have arisen through the application of CPR reimbursement principles, and**
- **to achieve short-term budget savings in ways that are more consistent with long-term policy directions than are across-the-board reductions in payments.**

However, for these goals to be reached, inherent reasonableness must be applied carefully through an open process that takes account of input from all interested parties.

The Commission will test a consensus process as an alternative means of developing recommendations for changes in payments based on inherent reasonableness. If this process is successful, the results would provide the basis for recommendations to the Congress and to the Secretary of HHS on inherent reasonableness.

The Commission notes that application of inherent reasonableness will increase allowable charges for some services as well as reduce allowable charges for others. Inclusion of increases need not preclude a net decrease in Medicare expenditures.

The process proposed by the Commission would not be available in time to advise Congress or the Secretary of Health and Human Services on matters of inherent reasonableness taken up during the current session of Congress. Nevertheless, the Commission could comment whether changes under inherent reasonableness proposed by Congress and the Secretary are consistent with longer-term policy directions advocated by the Commission.

The Commission would review evidence presented by HCFA and other interested parties and would examine existing relative value scales in the United States and abroad, particularly those that have bases other than existing charges.

CHAPTER 6

ASSIGNMENT AND THE PARTICIPATING PHYSICIAN PROGRAM

Since the inception of Medicare, physicians have been permitted to decide on a claim-by-claim basis whether to bill Medicare's carrier and accept the allowed charge as payment in full (the patient is to be billed only for the deductible and coinsurance), or to bill the patient for the full amount, with the patient also responsible for the difference between the billed charge and what Medicare allows. This difference is often referred to as a balance bill. Historically, physicians have accepted assignment for somewhat more than half of all claims, though the percentage has increased sharply in recent years, to 68 percent in FY 1986.

This policy has left beneficiaries exposed to substantial financial risks. In 1985 Medicare-allowed charges were lower than billed charges on 85 percent of unassigned claims, with the difference for claims that were reduced averaging 26 percent. Unlike the deductible and coinsurance amounts, for which about two-thirds of beneficiaries have purchased private supplemental insurance to limit risks associated with costly illness, balance-billed amounts are not covered by private insurance for most beneficiaries. According to the 1977 National Medical Care Expenditure Survey, only 41 percent of those covered by supplemental policies had any protection from the cost of additional charges for physicians' services delivered to inpatients, and 29 percent were protected for services performed outside of the hospital (Cafferata, 1984). Physicians are required to accept assignment for those beneficiaries also eligible for Medicaid.

DETERMINANTS OF BALANCE-BILLED AMOUNTS

Beneficiary responsibility for balance-billed amounts depends on the fraction of claims that are unassigned and the amounts by which unassigned charges exceed the Medicare-allowable charge. These in turn depend on a number of factors:

- the level of Medicare-allowed charges compared to billed charges;
- the nature of physicians' interactions with carriers;
- the ease with which beneficiaries can identify physicians who accept assignment; and
- the number of physicians.

The level of Medicare-allowed charges affects beneficiary liability through both the assignment rate and the size of additional charges for unassigned claims. When allowed charges are low compared to physicians' billed charges, physicians have less incentive to accept assignment (Paringer, 1980). Medicare-allowed charges have decreased relative to billed charges over time. Indeed, fears of increased burdens on beneficiaries have been a prominent factor in decisions by the Congress to seek relatively small reductions in Medicare payment levels.

Since assigned claims are billed directly to carriers rather than to patients, the speed and accuracy with which claims are processed and the responsiveness of the carrier to physicians' problems with claims are key elements in encouraging assignment. Difficulties in measuring the nature of physician-carrier interactions have precluded the gathering of systematic evidence, but physicians often emphasize the importance of ease of dealing with claims.

Many have noted the difficulty that patients have in trying to choose a physician on the basis of price, particularly during an illness. Choosing a physician on the basis of acceptance of assignment has not been much easier. Until the recent implementation of the participating physician program, all physicians were able to make assignment decisions on a claim-by-claim basis and had no responsibility to inform patients in advance.

Increased numbers of physicians per capita may reduce balance bills, since providing additional services to Medicare beneficiaries for Medicare-allowed charges only may be more attractive to physicians facing more competition. While only limited research is available to support this proposition, some feel that the increased supply of physicians has played a role in the increase in the assignment rate between 1977 and 1983, a period in which Medicare-allowed charges increased less rapidly than physicians' billed charges.

RECENT STEPS TO LIMIT BALANCE BILLS

Recent policy changes initiated by the Congress have attempted to limit balance bills by making it easier for the beneficiary to choose a physician who accepts assignment. In addition, direct limitations have been placed on some physicians' actual charges.

Participating Physician Program

Initiated in 1984, the Participating Physician Program (PAR) attempts to make it easier for beneficiaries who seek a physician who accepts assignment to find one through published directories of those who have agreed to accept assignment on all of their Medicare claims, In 1986, 28 percent of physicians providing Medicare services--accounting for 37 percent of Medicare approved charges--had signed participation

agreements. By disseminating information on physicians' assignment practices, the program has facilitated some beneficiaries' efforts to select or be referred to a physician who they know in advance will accept assignment. To the extent that beneficiaries become more discriminating consumers, this in turn will increase the incentives for physicians to accept assignment.

In the Omnibus Budget Reconciliation Act of 1986 (OBRA86), the Congress confirmed its support for the PAR program by enhancing it in several ways. It made permanent a 4 percent differential in prevailing charges between participating and nonparticipating physicians and exempted participating physicians from limitations on actual charges. It expanded the distribution of directories. It required carriers to recruit and retain participating physicians and authorized cash rewards to carriers that have the most success. And it required physicians to disclose in advance estimated payments that beneficiaries would have to make for some elective surgical procedures when assignment would not be accepted.

Evidence on the impact of the participating physician program is fragmentary. Part of the 14 percentage point increase in the assignment rate between 1983 and 1985 is probably due to the program.[1] Some physicians who accepted assignment part of the time now do so all of the time. The Commission does not yet know whether physicians' decisions on whether to participate have had significant effects on their patient loads--a key to the ultimate success of the program. The real test of the effectiveness of the program will not come until 1988, however, when the OBRA86 measures will have been fully implemented.

Limits on Charges

At the same time that the Congress took steps to encourage assignment through enhancements of the PAR program, it replaced the freeze on on actual charges of nonparticipating physicians with a series of limits. These limits include both a general cap on charge increases and limits on the levels of charges for procedures that have had payments reduced on the grounds of inherent reasonableness.

This is the first year of a four-year period over which increases in nonparticipating physicians' actual charges will be restricted. Physicians whose charges are relatively high will be restricted the most, but even those whose charges are lower than average will face restrictions on increases. Whether these restrictions are only a transition from the 1984-1986 freeze on charges or the beginning of a permanent policy of charge restrictions is not known.

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[1]Other factors affecting the assignment rate were the new requirements that laboratory claims be assigned and the freeze in Medicare-allowable charges that was in effect during much of the period.

When prevailing screens for cataract surgery were reduced by 10 percent on the basis of inherent reasonableness, actual charges for the procedure were limited to 125 percent of the prevailing charge. The Congress was sufficiently concerned about the possibility of large balance bills for this procedure that it limited them by direct regulation rather than depend on competition augmented by PAR directories and the new disclosure requirements. It is too early to assess the impact of these limitations on beneficiaries' liability for balance bills and access to care.

RECOMMENDATIONS FOR THE SHORT TERM

The Commission regards the above policy changes to be major ones. Some of the most important will be implemented for the first time during 1987. Consequently, the Commission's recommendations for the short term stress refinements and monitoring rather than major change.

> **RECOMMENDATION: Continual attention needs to be given to ways to make it easier for participating physicians to have their Medicare claims processed and to ways to increase beneficiaries' familiarity with the participating physician program.**

Streamlining participating physicians' collection of the deductible and coinsurance amounts for those beneficiaries having private supplemental coverage has the potential of materially increasing the attractiveness of participation to physicians without incurring large program costs. Carriers could either collect cost-sharing amounts from private supplemental insurers or transmit processed claims directly, with instructions to pay cost-sharing amounts to the physician. The Commission plans to explore a number of options in this area.

The Commission also plans to explore additional steps to help beneficiaries obtain information on the participating physician program and on likely additional charges by nonparticipating physicians. For example, carriers could provide beneficiaries with data on what physicians charge for their most common procedures. This information could include the proportion of claims assigned and the amount of additional charges typical in unassigned claims.

> **RECOMMENDATION: HCFA and the Congress should undertake substantial efforts to monitor the impact of the recent policy changes affecting assignment and beneficiary liability for balance-billed amounts.**

Monitoring is important both to refine policies and to make ultimate decisions on whether to retain them. The recent policy changes strike out in a new direction and consequently have uncertain effects. The sooner their effects are understood, the sooner the policies can be refined or extended.

FEE SCHEDULES AND ASSIGNMENT

As indicated in chapter 3, development of a fee schedule would require a reassessment of Medicare policies regarding assignment. Fee schedules considered by the Commission would likely mean substantial changes in the amount Medicare pays for some services. For those services for which payments are reduced, there is serious concern that corresponding increases in balance bills would follow, thereby jeopardizing beneficiaries' access to care and their financial protection. While balance billing might be unchanged for beneficiaries on the whole, it could be quite burdensome for those whose medical care needs required mostly services with lowered payments.

Since current policies regarding assignment are still in the process of implementation, their ability to prevent unacceptable decreases in beneficiaries' access to care and in their financial protection is not known. By facilitating the choice of a physician who accepts assignment and requiring advance disclosure of balance bills, these policies might preclude a significant portion of payment reductions from being shifted to beneficiaries. Should a decision be made during the next two or three years to implement a fee schedule, more would be known about the effectiveness of current policies. Substantial uncertainty is likely to remain, nevertheless.

Some suggest that a rationalization of the structure of fees would increase assignment overall. To the extent that some payments are too low to cover the costs of practice (examples of low prevailing charges for primary care in some rural areas were presented to the Commission), potential increases in assignment rates for those services whose fees were increased might more than offset decreases in assignment rates for services whose fees were decreased, so long as payments for the latter remain in excess of the costs of practice.

Should current policies regarding assignment be deemed inadequate in the area of beneficiary financial protection, the following options could be considered:

- moral suasion of physicians by their leadership to reduce balance billing;
- additional incentives for physicians to sign participation agreements;
- limits on actual charges; and
- mandatory assignment.

To the degree that physicians had substantial input into the process of changing relative payments, they might be less likely to increase balance bills to offset reductions in Medicare payments for those procedures with lowered payments. Substantial efforts on the part of the leadership of medical societies and organizations might be necessary for this to occur.

Alternatively, further steps might be taken to enhance the PAR program. These could involve either additional incentives for physicians to sign participation agreements, such as collection by Medicare of deductible and coinsurance amounts on behalf of participating physicians, or additional incentives for beneficiaries to obtain services from participating physicians.

Fee schedules could address the issue of balance bills by expanding the use of limits on physicians' actual charges. Such limits on actual charges permit balance bills, but limit their size either to amounts typically charged by a physician in the past or to a percentage of the Medicare-allowed charge. Thus for physicians to exceeding the limit, claims cannot be submitted to Medicare, and no coverage for the service is provided. Consequently, some of the gains in beneficiary financial protection may come at a sacrifice in access to care.

In contrast, mandatory assignment would not permit any balance bills. It would limit the payment of Medicare benefits to those services for which the physician accepted assignment. Presumably, the absence of payment from Medicare for unassigned services would make beneficiaries highly sensitive to physicians' decisions regarding acceptance of assignment, which in turn would induce physicians to accept assignment on more claims than under current policies. This would eliminate balance bills for many beneficiaries, but it could have serious effects on those beneficiaries unable to find a suitable physician who accepts assignment. These beneficiaries might be left with the choice of paying the entire bill themselves, or choosing a less suitable physician, or going without care.

The balance between those beneficiaries enjoying increased financial protection and those paying more or experiencing a reduction in access to care would depend on the overall level of payment and other factors. Mandatory assignment as a component of a fee schedule has been backed by some groups representing beneficiaries but has been opposed by organizations representing physicians.

In discussing options to limit balance bills under a fee schedule, one should not lose sight of the fact that Medicare payments for many services would increase under a fee schedule. For those services with increased payments, assignment rates would tend to increase, and balance bills for those services not assigned would be smaller.

WORKPLAN

The Commission will focus on three areas: analyzing the impact of the recent policy changes in this area, developing additional options to make participation more attractive to physicians (described above), and considering the implications of a fee schedule for policies regarding assignment. The assessment of recent policy changes will explore the following questions:

- Have physicians experienced caseload increases or decreases related to their decision regarding participation?
- Have physicians adjusted their fees in response to the participation program and any associated changes in beneficiary behavior?
- Have limits on actual charges led physicians to decrease services available to Medicare patients?

The Commission is familiar with work ongoing at HHS, and will coordinate its activities to avoid duplication of efforts. Monitoring the recent experience in Massachusetts, where the state government has linked physician license renewal with acceptance of assignment for Medicare claims, will be included in this assessment of recent policy changes.

PPRC will rely heavily on its evaluation of recent policy changes when it considers alternative assignment policies to be used in conjunction with fee schedules.

The Commission is concerned with reports that some physicians, when faced with the new requirements for mandatory assignment of laboratory tests conducted in their offices, have billed patients for their full charge and not submitted claims to Medicare. Since laboratory charges tend to be a small though significant portion of the bill, patients have often not been aware of the loss of Medicare coverage. In conjunction with its monitoring of the effects of recent changes in policies concerning assignment, the Commission plans to examine this issue and discuss options to deal with it.

CHAPTER 7

THE MEDICARE ECONOMIC INDEX

The rapid growth in Medicare payments to physicians during the latter part of the 1960s and early 1970s prompted a series of legislative actions aimed a restraining it. One such action was the development of the Medicare Economic Index (MEI), which ties increases in Medicare prevailing charges to increases in physicians' practice costs and wage rates throughout the economy.

BACKGROUND

The MEI is a weighted index of physicians' practice expenses and general earnings levels relative to a base year. The weights are based primarily on a special HCFA survey of physicians' revenues and expenses and are updated periodically. The portion of the index related to practice expenses has a weight of approximately 40 percent spread among the following six components:

salaries and wages of office employees	0.172
office space	0.100
drugs and supplies	0.040
automobile expenses	0.028
professional liability insurance	0.044
other expenses	0.016

The general-earnings component, which is weighted to reflect the net income component of physicians' gross revenues (approximately 60 percent), is the average weekly earnings levels of nonagricultural production and nonsupervisory workers in the overall economy. Earnings are net of increases in worker productivity to avoid double counting productivity-related gains (Dutton and McMenamin, 1981). A broad index of earnings is used rather than an index of physicians' net incomes to avoid the circularity of an index designed to limit physicians' fees being based on physicians' net incomes. The MEI's weights do not vary according to specialty or geographic location.

The MEI restrains the growth of payments to physicians by capping prevailing charges. Medicare's approved payment for a specific procedure is the lowest of a physician's billed charge, his or her customary charge for the procedure (median charge in the preceding year), or the prevailing charge for the procedure (the seventy-fifth percentile of customary charges in the area subject to adjustment). Beginning in 1976, the prevailing charge could not exceed the corresponding adjusted prevailing charge--the product of that year's MEI and the prevailing charge for the procedure in 1973, the MEI's base year. Consequently, adjusted prevailing charges in each of Medicare's nearly 240 charge areas

are a function of two elements: the MEI, which reflects national average increases in practice costs and general earnings over time, and prevailing charges in the area in 1973.

HCFA recently attempted to change the methodology used to calculate increases in the office space component of the MEI, an action which would have lowered the overall index significantly. In the Omnibus Budget Reconciliation Act of 1986, Congress responded by restricting HCFA's authority to change the MEI methodology. The restrictions will remain in force pending the outcome of a study by the Secretary of Health and Human Services, in concert with appropriate experts, on the relationship between the MEI and economic changes affecting physicians.

While HCFA has updated the weights in the MEI periodically, the index continues to be applied to the original 1973 prevailing charges. This has tended to preserve or freeze 1973 patterns of relative payments. Indeed, as the MEI has limited prevailing charges more and more over time, this effect has become more pronounced.

The tying of current payment limits to fourteen-year-old patterns of charges may be responsible for some of the distortions in relative values that so many are concerned about today. Charges for services for which productivity gains have been relatively small, such as office visits, may have been overly restricted compared with those services for which productivity advances have been relatively large. (Recall that the earnings component of the MEI is net of productivity advances for nonagricultural production and nonsupervisory workers.) Family physicians may have been particularly affected by the continued use of relative charges from 1973, a time when there were few family practitioners had residency training and when prevailing charges for such practitioners were, in some areas, determined by customary charges of general practitioners.

REBASING THE MEI

The Commission plans to assess the merits of rebasing the MEI, that is, changing the base year for computing adjusted prevailing charges from 1973 to a more recent year. For rebasing to be budget neutral--that is, for aggregate program payments for a given volume and mix of procedures to be unaffected--the adjusted prevailing charges would be calculated by applying a uniform multiplier or percentage discount factor to all prevailing charges in each area in the base year.

While the theoretical justification for such a rebasing is sound, the Commission wants to simulate the change with program data before making a recommendation. The inference that procedures whose charges have increased most rapidly have had the most rapid increases in practice costs should not be accepted without empirical evidence. The Commission wants to assess whether rebasing the MEI would indeed change relative payments in the direction that it contemplates a fee schedule would. If

not, rebasing would not be a step in the direction of policy reform but rather a digression.

In the course of examining potential rebasing mechanisms, the Commission will examine whether the discount that would be applied to prevailing charges in the new base year prevailing charges to achieve budget neutrality should be applied to the entire charge or only to the component that reflects physicians' net incomes. The philosophy behind the MEI--limiting fee increases to increases in practice costs and wage rates in the general economy--would seem to argue for applying the discount only to the physicians' net income component for each service.

Should this approach be pursued, it would not be practical to apply the discount rate to the net income component of each service. It would, however, be feasible to apply it by specialty and by broad geographic area (for example, urban versus rural). Thus services of physicians in specialties with relatively high overheads would have relatively smaller discounts from prevailing charges than others.

WORKPLAN

In addition to examining various methods of rebasing the MEI, the Commission will work with others on a general reevaluation of the structure of the MEI. The Congress has mandated a HCFA study of the MEI that will focus on how well it reflects economic factors affecting physicians who serve Medicare patients. The constituent elements of the index and their internal weights have not been changed or adjusted for several years, in some instances, not since the index was first implemented in 1976. Further conceptual arguments that elements of the MEI do not adequately represent physicians' practice costs and incomes have been set forth (American Medical Association, 1986). The Commission will follow the progress of the HCFA study and contribute to it where feasible.

CHAPTER 8

IMPROVING PROGRAM ADMINISTRATION

When Congress enacted Medicare in 1965, it delegated the administration of claims to private contractors. The Health Care Financing Administration (HCFA), among its other responsibilities, manages the contracting process, sets standards for contractors and evaluates their performance, and maintains essential program data.[1]

For the Supplemental Medical Insurance program, HCFA has contracts with 35 different contractors, known as carriers, who are responsible for 56 geographic sites.[2] These carriers processed over 300 million bills or claims in Fiscal Year 1986, and workload growth in 1987 is expected to push the figure to more than 333 million. In Fiscal Year 1986, the government spent approximately $619 million for the carriers' administrative activities.

In the early days of the Medicare program, carriers operated with relatively loose oversight by the Department of Health and Human Services (then, the Department of Health, Education and Welfare). However, concern for the quality of performance generally and dissatisfaction with the performance of some carriers specifically has led to much more rigorous supervision.

The Commission has heard representatives of beneficiaries, providers and carriers express many concerns about the current administration of the Part B program. These concerns focus on:

- the adequacy of carrier funding, given the complexity of the program and the value of tight program administration;
- the management difficulties created for carriers by the interaction of relatively inflexible line-item budgeting, highly detailed performance standards, and variable year-to-year funding levels for administrative subfunctions;
- HCFA's apparent relaxation of some standards for timely claims processing and its tolerance of carriers that are persistently bad performers; and

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[1]HCFA also oversees the participation of Health Maintenance Organizations and Competitive Medical Plans in the Medicare program and pays them directly under terms of either cost- or risk-based contracts.

[2]Part A intermediaries, rather than carriers, process claims for hospital outpatient care.

- the need for additional research on the effectiveness of benefits cost management functions such as utilization review.

If Congress adopts a fee schedule, the switch from CPR will impose significant administrative burdens on HCFA and the carriers. Improvements in program management and performance that are made now can pave the way for a smoother transition later.

ADMINISTRATIVE FUNCTIONS OF CARRIERS

The responsibilities of Part B contractors have evolved and multiplied over the years because of new legislation and more intensive management by HCFA. Three broad responsibilities can, however, be delineated: claims processing; payment safeguards; and beneficiary and provider service.

Carriers are responsible for paying claims in an accurate, timely, and fiscally prudent manner. Upon receipt of a claim, they confirm whether the beneficiary is eligible, whether the claim is for a covered service, and whether a duplicate claim has been filed. They also determine the level of payment based on the CPR payment methodology. This involves pricing claims, calculating maximum allowable charges, determining inherent reasonableness, and other tasks. For new medical procedures, carriers determine the initial level of reasonable payment.

Carriers are also responsible for ensuring that payments are made only for medically necessary services. They profile and analyze physician practice patterns, screen bills and deny claims for unneeded services, and perform additional activities to control excess costs from the overuse of services. A relatively new safeguard function is to ensure that Medicare functions only as a secondary payer when another party has primary liability (the Medicare Secondary Payer program or MSP).

In addition, carriers answer inquiries from beneficiaries and providers of care, resolve problems, and educate beneficiaries and providers about their rights and their responsibilities under the Medicare program. (Education is essential given the frequent and extensive changes in the program.) Carriers also process appeals when a beneficiary or provider is dissatisfied with the initial determination on a claim. Following the adoption of the participating physician program in 1984, carriers have undertaken new functions in administering that program.

AGGREGATE FUNDING LEVELS

Prudent carrier administration of the Medicare program has multiple advantages, including control of benefit outlays, timely and accurate payments to beneficiaries and physicians, and improved provider

cooperation with the program. Severe funding constraints and the prospect of further budget crises have prompted warnings to HCFA that inadequate funding is counterproductive.

In FY86, Medicare spending on carrier administrative functions amounted to about 2.5 percent of total SMI costs of over $26 billion.[3] With government administrative expenses added in, the figure rises to about 4 percent. This level compares favorably with those for private health benefit programs, although strict comparisons are not possible. Part A administrative costs are considerably lower, less than 0.5 percent of total spending. This difference reflects the larger dollar size of claims for hospitalization.

Per claim processing costs have been dropping steadily, even without adjustment for inflation. This is due, in part, to efficiencies generated by the carriers and, in part, to HCFA's oversight, the consolidation of carrier areas, and the automation of many functions.

However, there is some concern that part of the reduction in unit claims costs has a more negative explanation: underprojection by HCFA of the rapidly rising claims workload; inadequate Administration budget requests for claims processing; and diversion of funds from claims processing to accommodate unexpected program changes in such other areas as new payment safeguard activities (General Accounting Office, 1986). To the extent that these factors play a role in reduced unit claims costs, a side effect is higher claims backlogs, increased error rates, poorer service and other problems.

In recent years, Congress has tended to adjust the Administration's budget requests upward. For example, it added almost $50 million to the Administration's FY87 request for Part A and Part B claims processing. More than 75 percent of claims processing funds go for Part B activities. For payment safeguard activities, nearly $18 million more was appropriated than requested. The SMI portion accounts for about 60 percent of payment safeguard funds.

Information in an April 1986 GAO report suggests not only that the Administration's budget requests are low but that HCFA's budget-information base is biased in some respects. For example, by saying that in FY85, it would recognize only those costs that were in line with the cost caps the agency had established, HCFA was seen as signalling carriers to report their costs only to the extent that they were in line with these caps. For FY86, most contractors presented two budgets for claims processing--a higher one reflecting estimated actual costs and a lower one showing numbers consistent with the cost caps. Thus, this

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[3]This figure excludes administrative and benefit expenses for outpatient care, which is handled by Part A intermediaries. If these expenses are included, the share goes to about three and a half percent.

information base, a crucial resource for the Congress, may have distortions that undermine Congressional efforts to develop reasonable contractor budgets. Supplemental information provided directly to Congress by carriers and other interested parties cannot compensate fully for distortions in HCFA's substantially richer information base.

Given the looming budget deficits, the potential for future crisis-driven responses to these deficits, and the prospect of reform in methods of physician payment, it is important to emphasize now that underfunding for the administration of Medicare is financially shortsighted as well as damaging to beneficiaries. The administrative funds are proportionately so small and the benefit outlays so large, that administrative savings can be easily offset if not dwarfed by uncontrolled benefits outlays.

Adequate funding for claims processing can reduce total benefit outlays in several ways. It supports qualified staffing for the accurate determination of coverage, eligibility and payment amounts. It also permits the analyses needed to establish reasonable prices for new services and provides for extra resources to check for duplicate claims. One study of five carriers found a 32 to 1 savings ratio, that is, $32 saved for each dollar spent for pricing, eligibility and similar carrier functions (General Accounting Office, 1986).

Adequate funding of payment safeguards also produces economic benefits. HCFA has estimated savings ratios of 9 to 1 for carrier medical review. Initial savings from the Medicare Secondary Payer program are estimated at 20 to 1. Even funding for services to beneficiaries and providers has an economic payback because it helps ensure that claims are accurate when they are first filed.

Certainly, beneficiaries are harmed and frustrated directly by inadequate carrier service and poor processing of claims. They also may suffer harm indirectly. If physicians become frustrated with poor service and slow, inaccurate payment of assigned claims, they may refuse assignment. This then subjects beneficiaries to the challenge of obtaining direct payment from Medicare and exposes them to potential balance bills and higher out-of-pocket costs.

The Commission is concerned about the impact on beneficiaries and physicians of an upward trend in average claims processing times. The President's budget request for FY88 estimates that average processing time will be 20 days for FY87 and 26 days for FY88 (Congressional Research Service, 1987). In contrast, average processing time for carriers was 15 days at year-end 1986. The budget request seeks to raise the ceiling on processing times for most claims above the levels specified by Congress in the Omnibus Budget Reconciliation Act of 1986.

RECOMMENDATION: Adequate funding for Medicare administration should be recognized as critical to protecting beneficiaries and containing benefit costs. Funding levels should reflect the complexity and scope of program requirements.

ADMINISTRATIVE FLEXIBILITY AND STABILITY

As HCFA has expanded and strengthened its oversight role, carriers have faced increasingly detailed budgets and performance standards. Stronger supervision has probably helped improve carrier performance, but the oversight may have become overly rigid and constraining. Some observers have cited increasing "micromanagement" of HCFA by the President's Office of Management and Budget as a major contributor to this problem and a pattern deserving investigation by Congress or the Commission.

The combination of line-item budget constraints and highly detailed, process-based performance standards interacts with tight funding and year-to-year funding instability to undermine efficient resource management by carriers. For example, carriers find it difficult to attract qualified personnel, such as trained utilization review specialists, to jobs that may not last more than a year. And even if trained staff could be hired, carriers may be reluctant to fill funded positions with people who might have to be laid off or relocated a year later (Blue Cross and Blue Shield Association, 1983; Keller, 1986). In general, carriers are concerned that layoffs, understaffing and extensive use of part-time workers are reducing the quality of all carrier functions and limiting their capacity for management, especially over the longer term.

Particularly where savings and other performance results can be satisfactorily measured, carriers should be allowed greater discretion to direct more funds to areas of higher yield. For example, some carriers have their own effective secondary payer program, and employers and providers in their service areas are generally well educated in identifying primary insurance liability. Such carriers may get little additional yield from higher funding of this function but could achieve savings by correcting problems with, say, duplicate claims.

HCFA has authority to experiment in this area. A pilot project to test more flexible funding and performance specifications is being planned but will probably be delayed because of tardy specification of individual carrier budgets for Fiscal Year 1987. Additional research on the effectiveness of various cost-management strategies should also help HCFA and the carriers in effectively designing and implementing more flexible carrier budgets.

In sum, HCFA has made progress in developing carrier performance standards, and this effort is to be commended. Now, however, it would be valuable to determine where these detailed specifications are most

productive and where they might be modified to permit more carrier flexibility.

RECOMMENDATION: HCFA should permit carriers greater flexibility in allocating administrative funds to the most productive uses.

IMPROVING CARRIER PERFORMANCE

HCFA has improved its oversight of carriers, although the agency, like the carriers, has suffered from budget cutbacks and reduced staffing. At the urging of both the General Accounting Office and carriers concerned about inconsistent and subjective evaluation, HCFA initiated development of its Contractor Performance Evaluation Program (CPEP) in the late 1970s. In 1985, HCFA regional offices applied nearly 80 CPEP standards to each carrier. Twenty standards were considered critical elements with failure on any one leading to failure overall.

CPEP has been and still is very process oriented, although HCFA is gradually focusing more on results. Today, however, rigid application of detailed process requirements may result in the failure of carriers to meet key standards for essentially minor reasons. This may encourage carriers to focus on the details of performance measurement to the detriment of overall efficiency and service.

Some problems and complaints about physician payment administration are probably inevitable given the complexity of the SMI program, the frequency of program changes, and the ordinary constraints of the budget process. There remain, however, significant concerns about program management, specifically, that the Administration has relaxed its commitment to strong claims processing performance, and the participation in the program of persistently weak performers is inappropriately tolerated.

The negative impact of several years of tight funding and increased workloads is evident in the statistics on claims process performance (General Accounting Office, 1986). Compared to 1980, average processing times in 1985 were up 16 percent for claims submitted by beneficiaries and 26 percent for those submitted by providers. Claims pending at year's end had jumped from 4.4 million to 11 million in the same five-year period, and average days of work on hand had risen from 6.9 to 9.4. In testimony last year before the House Ways and Means Subcommittee on Health, one carrier noted that increasing claims backlogs add to net administrative costs rather than reducing them because duplicate claims are increased as are beneficiary and provider inquiries (Carter, 1986).

HCFA has attempted to limit trust fund outlays by discouraging what it calls overly prompt payment to beneficiaries and providers. These actions, though apparently short-lived in their most extreme form,

combined with the strategy of low budget requests described earlier, have led some to question the Administration's commitment to timely and accurate claims processing.

The threats to benefit cost containment posed by weak performance in claims processing, particularly higher payment error rates, have already been outlined. One further observation comes from carrier testimony at the December 1986 meeting of the Physician Payment Review Commission: "Too little attention is paid to these critical steps (of claims processing) . . . . Not only do we save considerable dollars on the front-end, but it is the front-end that feeds the . . . payment safeguard activities (and their results)" (Keller, 1986).

Beneficiary and provider service has also suffered during the budget crises of the 1980s. A lawsuit by a consumer group has directed more attention to adequate telephone responses to beneficiaries' queries. Also at the instigation of the courts, HCFA is supposed to fund work to make more readable the written explanation to beneficiaries of carrier benefits determinations. The Medicare program is so complex and rapidly changing that even a well-funded education program could not eliminate all ignorance and confusion, but poorly funded efforts simply magnify for beneficiaries and providers the problems that are created by complexity and change.

In addition to concerns about the Administration's commitment to strong claims processing performance, there is concern that the continued poor performance of some carriers is unjustifiably tolerated. Carrier performance does vary substantially. Payment error rates have varied by up to eight-fold, with the range in 1984 going from a low of 0.4 percent to a high of 3.2 percent. Average claims processing times show similar variation, ranging from a low of 6.5 days to a high of 42.4 days in mid-1985 (General Accounting Office, 1986).

Between 1980 and 1985, HCFA dropped two carriers because of poor performance. The agency is now operating under statutory authority that allows it to drop up to four of the poorest performing contractors. During the Fall of 1986, HCFA replaced one intermediary and one carrier, and two more intermediaries may be replaced in 1987.

In general, HCFA's emphasis on correcting bad performance rather than replacing contractors is warranted because of the important financial, service, and other problems created by replacement. However, HCFA has proceeded with several carrier replacements as part of its consolidation and fixed-price contracting initiatives, but performance has not been a factor in the selection of the territories in which the changes have been made nor in the selection of the carriers to serve them. At a minimum, when consolidations or fixed price contracts occur, the performance of the carriers involved should be a significant factor in decisions.

Recently, HCFA has begun to reorient CPEP away from yearly review of all carriers for all standards and will, instead, focus on the most critical standards and the carriers with histories of performance problems. This shift in emphasis should help eliminate the worst performance problems, either through correcting carrier weaknesses or eliminating persistently bad performers from the program. Outright removal of the poorest performers reinforces the federal government's credibility for one of its most visible and valuable programs, not only for all contractors but also for beneficiaries and physicians.

RECOMMENDATION: Strong standards for carrier claims processing--speed, accuracy and service to beneficiaries and providers--should be a priority. Persistently poor performers should be eliminated from the program.

BENEFITS COST MANAGEMENT

An effective payment system includes not only the method of payment, such as a fee schedule, but also a variety of other elements such as utilization review and quality assessment. No payment method can by itself achieve all the varied and sometimes conflicting goals of the Medicare program.

Since the initiation of Medicare, carriers have expanded the scope of medical review, provider education, and other activities intended to guard against inappropriate payment. As noted earlier, HCFA has in CPEP a detailed system of performance monitoring and evaluation. Nevertheless, more comprehensive research on the effectiveness of carrier activities would be desirable. The HCFA data base, the number of carriers, and the range of activities provide a good foundation for such an effort. In addition, the growth of private-sector programs and data offer HCFA the opportunity for even broader comparisons of strategies and outcomes.

The medical review activities of carriers can be used as an example. Currently, carriers vary substantially in their administration of medical review. Some of this variation may reflect a sound adjustment to specific local circumstances and problems. Nonetheless, the effectiveness of different approaches is not well or widely understood, particularly the extent to which they result in indirect versus direct savings. Direct savings come from claim denials or payment reductions for medically unnecessary or inappropriate care. Indirect savings come from behavior changes that eliminate inappropriate practices before claims are ever generated. This is the so-called sentinel effect.

Private payers who have attempted to evaluate both kinds of savings have found evidence that savings from deterring costs can greatly outrun direct savings, a desirable result in that beneficiaries are not subjected to unnecessary care and confrontations over claims denials are avoided. The

problems with documenting these savings are the very troublesome ones of measuring nonevents.

HCFA has an ambitious program for FY87 to evaluate the efficiency of carrier medical review screens. Other steps in the medical review process, such as provider follow-up, deserve attention along with the potential for indirect savings from activities that may not generate significant direct savings.

The relevance of private-sector innovations also deserves continued attention. For example, individual benefits management programs, often called high-cost case management, are growing. These programs actively seek opportunities to substitute less expensive services or sites of care for specific severely or chronically ill patients, such as stroke or head trauma victims. To protect the patient financially, this kind of substitution may require waivers of such benefit contract provisions as those limiting payment for home care. Medicare should consider funding a demonstration project to test the value of individual benefits management for selected categories of Medicare patients.

Also important is an assessment of the effects of prospective payment and PRO review on the utilization and quality of both inpatient and outpatient physician services. Beyond the scope of this chapter and this report is the question of what are the advantages and disadvantages of integrating all or some Part A and Part B contractor functions.

RECOMMENDATION: HCFA should expand research to identify cost-effective utilization review and other techniques used by carriers, PROs, and private payers to manage benefit costs.

WORKPLAN

In the coming months, Commission staff will monitor the progress of the FY88 budget for Part B administration, track the reorientation of CPEP, and follow the implementation of HCFA's projects on medical review and administrative flexibility. Prompt payment policy and administration will be a particular concern. Priorities will be established for the investigation of PRO activities, the assessment of research on new and existing benefits management techniques, and the monitoring of developments in HMO performance review and standard-setting.

The Commission will evaluate the administrative and budgetary implications of its substantive proposals for change in Medicare physician payment. These implications involve funding levels, operational feasibility, implementation timetables, and evaluation criteria.

CHAPTER 9

OTHER ISSUES

PROCEDURE CODING

To describe and record services provided to patients and billed to Medicare and other third-party payers in a more uniform manner, various procedure terminologies and coding systems have been developed. The system now required for use by carriers in reporting data to HCFA is the Common Procedure Coding System (HCPCS). This system is a combination of the American Medical Association's *Current Procedural Terminology Fourth Edition* (CPT-4), used for most physicians' services, and additional codes to describe other services covered by Medicare, such as provision of durable medical equipment.

Before 1983 carriers could use any coding system for reporting to HCFA. The most common systems were versions of the California Relative Value Studies and earlier versions of CPT. These systems were originally developed not for reimbursement purposes but for general medical record-keeping. The standardization of varied English language descriptions of services and the translation of those descriptions into four- or five-digit numerical codes allowed for more uniform, accurate, and compact recording of services.

These codes also made it easier to record services for the purpose of claims processing. Approved charges were established for each code representing a covered service. When extraordinary circumstances associated with a particular instance of service justified a different approved charge, an additional set of two-digit modifiers was used to designate a level of service greater or lesser than usual. This created a six- or seven-digit code that could also be used in claims processing.

There are currently more than 7,000 codes available for physician services in CPT-4. Previous work by West, McMenamin, and Marcus (1986) found that among four of the first Medicare carriers to convert to HCFA's Common Procedure Coding System, fifty to sixty five-digit HCPCS codes accounted for at least 50 percent of total approved charges. No more than 11,000 unique combinations of codes plus modifiers were used by any carrier, and at least half of these unique combinations of codes accounted for less than 1 percent of approved charges for each of the four carriers studied.

Procedure codes can describe either specific services or packages of services. Most codes for surgical services represent a package of services: the surgery itself and varying amounts of presurgical and postsurgical services. Describing the surgical package with a single code is referred to as global billing. Medicare carriers' administrative rules

may reinforce global billing styles. For example, they may not approve (without additional justification) payment for any followup service billed by a surgeon for a particular patient within thirty days following the date of that patient's surgery.

These procedure coding systems may not be well suited for purposes of determining payment. The original purpose of these systems--recording the process of medical care--may not be congruent with their use in claims processing.

The existence of thousands of codes allows services to be described in very fine detail, but may provide an opportunity for physicians to "unbundle" services (that is, to bill separately for services commonly provided and previously billed as part of a single package). Although unbundling is thought to occur most commonly with services provided with physician visits, global billing of surgery may also be affected. For example, followup visits previously included as part of the package of services may be billed separately.

The definition and grouping of services presumed to be included in surgical global fees is now left to the discretion of individual carriers. But these definitions may not be sufficiently precise. Consequently, some codes used may not represent the same combination of services from one case to another or from one carrier jurisdiction to another. Improving the definitions of codes, such as standardizing the amount of postoperative care covered by global fees, would eliminate this problem. It could also reduce the incentive to bill separately for services such as postoperative visits. Standardizing codes, including those for surgical procedures, is a necessary prerequisite to implementating fee schedules to pay for physician services.

A second range of concerns about coding involves the multiplicity of codes and the generation of new codes that may or may not reflect changes in technology. Where the coding systems present a range of services that may be close substitutes, physicians have incentives to bill under the code that generates the highest approved charge. To the extent that physicians respond to such incentives, this "upcoding" may generate increased physician revenues and program expenditures without changing the specific services rendered to patients.

Similarly, although new techniques warrant new entries in procedure terminology, a variety of new descriptions has been introduced that may not reflect significant changes in technology. For example, CPT-4 has separate sets of codes for office visits, home visits, hospital visits, visits to skilled nursing facilities and other long-term-care facilities, emergency department visits, ophthalmological visits, and critical care visits. Despite the potential for upcoding and additional work for the carriers involved in maintaining more fee screens, HCFA does not have control over this process. It automatically accepts all updates of CPT-4.

The Omnibus Budget Reconciliation Act of 1986 directed the Secretary of HHS to study the potential for reducing the number of codes used by carriers for payment purposes, including merging of similar codes into a single category with one code. This could minimize inappropriate increases in the intensity or volume of services billed by reducing code distinctions that do not reflect substantial differences in services rendered. New groups of aggregated codes are to be instituted for payment purposes no later than July 1, 1990.

> **The definition of codes for medical and surgical services, including standardization of services covered by global fees for surgery, should be refined and standardized. The Commission will convene an expert panel to make recommendations for change. If successful, the Commission would then advise HCFA on completion of the process.**

The Commission has established a subcommittee of its members to begin this work. In addition to standardizing and improving the definitions of codes, the Commission will examine whether the number is codes can be reduced, both by aggregating them and eliminating unnecessary ones.

The use of consensus panels can take advantage of expertise in the process of developing standards. A number of decisions must be made in establishing more precise definitions of global fees. For example, for each type of procedure, the global fee could cover the period encompassed by normal uncomplicated recovery and include at least the first postoperative ambulatory visit, if a visit is necessary.

ASSISTANCE AT SURGERY

Medicare Part B typically pays for assistance at surgery by physicians, physician assistants and certain hospital staff.[1] Serious doubts have been raised about how frequently physicians in particular are really needed as assistants and, therefore, whether payment by Medicare is appropriate.

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[1]Physicians are paid directly by Medicare under the CPR method. The Omnibus Budget Reconciliation Act of 1986 authorizes coverage of selected services of physician assistants, including assistance at surgery. This assistance is paid at 65 percent of the reasonable charge for a physician acting in the same capacity. Hospital staff are covered under the applicable DRG. The Omnibus Budget Reconciliation Act of 1982 generally prohibits Part B reimbursement for assistance at surgery in hospitals where an approved training program exists in the specialty and where a qualified individual on the staff is available to provide the services.

One type of evidence supporting these doubts is the variation among geographic areas in the use of physicians as assistants for some common surgical procedures (Mitchell et al., 1984). Anecdotes suggest that surgeons sometimes experience considerable pressure from referring physicians to use them as assistants.

The Consolidated Omnibus Budget Reconciliation Act of 1985 limited Part B payments for assistants at surgery during cataract procedures unless preauthorized as medically necessary by a PRO or carrier. The legislation also directed the Secretary of Health and Human Services to report on additional procedures for which the use of such assistants was a questionable necessity. In addition, the Act specified that the Physician Payment Review Commission should review the issue of assistance at surgery.

Whether or not the law's restrictions are expanded to other procedures, standards for judging the appropriateness of Part B payment for assistance at surgery are needed. Although the Secretary of HHS may propose additional procedures for which an assistant is seldom required, clear guidelines are still necessary to judge procedures in which assistance is sometimes but not always called for. Carriers remain responsible for processing claims in a fiscally prudent manner, paying only for services that are medically necessary.

Concern has been expressed that carriers and PROs should be provided additional guidance on administering provisions for assistants at surgery to achieve nationally consistent, responsible payment decisions. Although local discretion and knowledge have their place in administering the Medicare program, standardizing some definitions and guidelines is desirable. Such definitions and guidelines have to be clear and easily applied by carrier employees who lack extensive medical training. If workable, effective guidelines can be adopted, the more intrusive and expensive preauthorization procedure may be unnecessary.

RECOMMENDATION: Medicare limitations on Part B payment for assistance at surgery should be supplemented by additional definitions and guidelines.

- **Assistant at surgery should be defined as an individual who has the necessary qualifications to participate in the particular type of operation and who actively assists the surgeon in performing the surgical procedure. Other situations should be evaluated on a case-by-case basis.**

- **Practical claims review guidelines should be specified so that carriers can assess the need for an assistant based on the complexity of the procedure, the possibility of patient complications, and the expected contribution of the assistant to the outcome.**

The Commission can further this goal through assisting HCFA to develop such guidelines. Clearly, extensive participation of surgeons is important to success in this endeavor. PPRC plans to test consultation processes that would develop guidelines using panels of physicians and other experts. Based on this experience, the Commission could then recommend an approach for HCFA to follow. The Commission will also examine the implementation of the preauthorization requirement for cataract surgery to determine whether it is working satisfactorily or whether an alternative approach would be desirable. As the Commission considers payment issues more broadly, other options, such as including an amount for assistants at surgery in a global fee to the surgeon, will be considered.

IMPROVING DATA

Timely, relevant, and accurate data are crucial to the consideration of major reforms in Medicare physician payment methods. Good data are also central to program management, including quality of care assessments and utilization review. Furthermore, they are essential for research and program evaluation and for monitoring the effects of policy changes. The Commission encourages well-planned efforts to improve the availability and quality of Medicare data.

In this report the PPRC has identified a number of payment reform issues. These include fee schedules, geographic variation, inherent reasonableness, assignment, the MEI, and program administration. Implicit in the discussions and work plans of each chapter are requirements for data on the workings of the Medicare program. Existing Medicare data bases might support some of the Commission's proposed analyses.

Medicare Data

Most HCFA data on physician payment are derived as a by-product of the Medicare claims payment system. Physicians and beneficiaries submit claims to carriers who in turn determine reasonable charges. Periodically, carriers prepare specific data files from those claims and transmit them to HCFA. One of the most widely used files for research has been the Part B Bill Summary Record file, which includes all claims for a 5 percent sample of beneficiaries. The file includes selected charge and payment data summarized by type and place of service (for example, hospital or physician's office) but not by geographic locality or procedure code. Another useful file is the Directory of Prevailing Charge Records which contains charge and frequency data on the 110 most frequently performed

Medicare physician services in each locality. This file was discontinued after fee screen year 1984.

HCFA's recently implemented Part B Medicare Annual Data system (BMAD) includes a number of related files that together provide much more detail on Medicare claims than the Bill Summary File. The procedure file provides data on frequencies and submitted and allowed charges for each procedure. The prevailing charge file is also organized by procedure and includes prevailing charges and other data by locality. The physician file includes information on all claims for a 5 percent sample of physicians. The beneficiary file includes information on the claims experience of a 5 percent sample of beneficiaries. Both the physician and beneficiary files contain data at the procedure level.

Data Limitations

BMAD and other HCFA files are the primary sources of Medicare charges and frequencies of physician services. These data are useful for assessing geographic variation in Medicare charges, simulating the fiscal outcomes of alternative fee schedules, and identifying patterns of charges and payments that warrant examination with respect to inherent reasonableness.

However, these data can only be used for preliminary investigations of these issues. The files contain limited information on the geographic locality of the charge and payment data they report. In some cases data are reported by prevailing charge locality, in others by zip code of the provider's billing address, and in others only by the carrier's entire service area. These limitations constrain the level of detail in analyses of geographic variation in charges and other investigations where locality is an important factor. Moreover, the BMAD files are relatively new and of uneven quality.

Medicare claims files are also of limited use in analyzing beneficiaries' out-of-pocket costs for physician services--especially balance bills--and the relationships between those liabilities, assignment rates, and the participating physician program. Although the maximum possible out-of-pocket liabilities can be computed from routinely collected Medicare claims data, actual financial liabilities cannot, because claims data do not include information on what physicians attempt to collect from beneficiaries.

These data limitations can restrict the scope of analyses of issues such as the effectiveness of the participating physician program in enhancing financial protection for beneficiaries, the effects of charge limits (like the Medicare fee freeze) on beneficiaries' out-of-pocket costs, and the role of private supplemental coverage. Special surveys of beneficiaries are necessary to augment claims data in these areas.

Medicare claims provide very limited information on patients and the details of their treatment. They provide either no information or poor information on patient health status before and after treatment, primary and secondary diagnoses, and the overall course of treatment. As was discussed earlier, lack of precision in coding makes analysis of variations in treatment patterns especially difficult.

Limitations in medical information on patients is particularly problematic for assessing the quality of care. Measuring quality of care is a major focus of attention for providers, payers, and patients, and many recommendations can be expected on improvements in defining and measuring quality. Some improvements are likely to involve such changes in data on claims as the addition of better diagnostic information. Other improvements will involve separate data collection efforts, including direct review of medical records.

Improvements in Medicare Data

The quality and quantity of data on the Part B program are steadily improving, and further improvement is likely. The development and implementation of the BMAD system was a major step forward. Beginning with 1983 data, the system consolidated and organized carrier-submitted claims by beneficiary, physician, and procedure. A requirement that carriers adhere to HCFA's common procedure coding system (HCPCS) when reporting BMAD data enforces a consistency among carriers that was missing in earlier files. BMAD is superior to traditional HCFA research data bases in the scope and detail with which charges, payments, service frequencies, and other claims data are reported.

Although the 1983 and 1984 versions of BMAD suffered from coding and reporting problems that plague implementation of any new data base, HCFA has been working to improve the file's reliability and consistency. The Commission appreciates these efforts, and looks forward to making extensive use of these files for analysis.

HCFA's initiative to link Medicare Part A (hospital) with Part B (physician) data is a possible source of information on total Medicare services delivered during a hospitalization. These linked data will greatly improve the ability of program managers and researchers to monitor and analyze many dimensions of hospital-based care. Furthermore, with the highly reliable diagnostic data recorded in Part A files, the linked files will permit analysis of physicians' billing and coding practices for services delivered to patients with similar diagnoses.

All improvements to the Medicare data system need not be as ambitious as the development of BMAD. The mandate of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) that the administrator of HCFA implement a system for uniquely identifying individual physicians by July 1987 is an example. Today analysis of the effects of policy changes on physicians is limited by researchers' inability to distinguish between an

entire group practice, an individual physician, or one among a number of locations where a physician practices. There is little uniformity among carriers' systems of physician identification. The Commission encourages HCFA to complete this task expeditiously and to develop and use a standard Medicare physician identifier.

The Commission will participate in data development work groups sponsored by HCFA and other agencies within Health and Human Services and other Federal departments. It will assist data development activities where feasible, offer suggestions for improving BMAD or other Medicare data files when possible, and identify needs for additional data collection efforts whenever the opportunity arises.

CHAPTER 10

ISSUES DEFERRED TO LATER REPORTS

QUALITY OF CARE

The Physician Payment Review Commission places high priority on the goal of access to high-quality care for all Medicare beneficiaries. The Commission will focus closely on how alternative methods of physician payment could influence quality of care and on methods to assess and ensure quality under each system.

Under the current system, some services are reimbursed more generously relative to costs than others. Many suspect that this leads to overprovision of more highly profitable procedures. A fee schedule with relative payments among services that are more in line with costs of production would reduce financial incentives for physicians to provide one service over another. Unbiased selection of services for each patient could lead to improvements in the effectiveness and quality of care.

Though a fee schedule could improve the mix of services provided to patients by changing relative financial incentives, an incentive would remain to increase the volume of services provided, including services of little or no benefit. Other means might be used to reduce the provision of services that have minimal benefit, such as increased utilization review and quality assessment, though the effectiveness of these programs is uncertain at this point. This would increase the efficiency and perhaps the quality of care.

Similarly, payment for physicians' services through capitation or large packages of services such as an inpatient case (physician diagnosis related groups) provides a financial incentive for underusing services. Quality of care may suffer, particularly if the physician is placed at significant financial risk. This incentive to skimp on services might also be controlled by utilization review and quality assessment.

Some policymakers advocate increased use of market forces in health care. The use of market forces to improve the effectiveness and efficiency of medical care depends on an informed buyer: the ability of the buyer or his representatives to appreciate the contribution of medical services to both the cost and the quality of his medical care. The ability to assess quality is critical to effective use of market solutions in medical care.

There is considerable research and development activity to improve quality assessment and utilization review. The determinants of quality of care are becoming better understood. The Commission intends to assess

current knowledge and research, and to determine how quality assessment and utilization review can be used in conjunction with payment reform to further the goals of the Medicare program.

SPECIALTY VARIATIONS

Distinctions among specialties, now used in determining approved charges under the CPR payment method, raise several separate but related issues. The current system allows for different approved charges for what appear to be identical services. Under the CPR payment method, distinctions among specialties are based on data about actual charges, and the use of specialty groupings for establishing prevailing charge limits is widespread among Medicare carriers. While a physician's customary charge for a particular service is determined solely on the basis of his or her submitted charges, the use of specialty groupings can result in the establishment of different approved prevailing charges for the same procedure performed by physicians in different specialties.

In addition, the CPR process has resulted in apparently large differences in approved charges for procedural as opposed to nonprocedural services. These differences can indirectly exacerbate the imbalances among specialists and generalists because of the greater opportunities for procedure-oriented care among specialists.

The Commission considers these to be important issues because differential payment rates among physicians both may reflect inequities that should be eliminated and may create adverse incentives regarding choices of specialty that affect access to appropriate physician services. Indeed, inappropriate differentials in approved charges for different categories of procedures and services are addressed in Commission recommendations on inherent reasonableness, and all issues related to specialty imbalances will be taken up in the development of recommendations on a fee schedule.

In addressing these issues, the Commission will consider short- term adjustments in the current CPR payment method to alleviate the most pressing existing distortions. It also will consider options such as fee schedules that would eliminate undesirable differentials through a more comprehensive restructuring of the way physicians are paid.

There are a number of key issues that the Commission will take into account in its analysis of specialty differentials.

Determination of the Content of Seemingly Identical Services for Payment Purposes. While this is a problem for various types of services, office visits appear to account for the largest and most consistent specialty differentials. It has been suggested that, although there are multiple

procedure codes for office visits, they may not be refined sufficiently to reflect the content of a given office visit and that the specialty differential may be a way to compensate for that deficiency.

Accounting for Potentially Important Factors in Determining Appropriate Differentials. The issues include whether and how to account for such factors as skill, experience, complexity, urgency and/or severity of the patient's medical problem, stress, intensity of effort, opportunity costs associated with training and board certification.

Identification of Specialists and Specialty Services for Payment Purposes. Currently, definitions of specialist or generalist are left to the carriers. In many cases, self-designation is allowed for payment purposes. An alternative approach to reduce existing variation would be to have nationally uniform definitions for specialists. Basing definitions on the types of services the specialist is particularly trained to provide raises some important issues. The first concerns whether differential fees should exist between qualified specialists providing the specialty services and generalists providing those same services. The second concerns the desirability of defining selected specialty services when provision by a generalist is considered inappropriate, thus limiting payment for those services solely to qualified specialists.

SECOND SURGICAL OPINION

Medicare currently pays when a beneficiary seeks a second physician's opinion about a recommended course of treatment. HCFA has funded demonstration projects to test the value of organized voluntary second surgical opinion (SSO) programs in Medicare. No projects have tested mandatory programs, although considerable experience with mandatory programs has been derived from Medicaid and private health benefit plans. The experience of the latter is probably most relevant for Medicare.

Private insurers generally agree that coverage for voluntary second opinions is a modest but worthwhile vehicle for promoting informed patient choice. In contrast, full-scale mandatory second opinion programs have provoked much disagreement. Most insurers offer employers the option of incorporating mandatory SSO in their benefit plans.

The arguments for mandatory second opinion are that it can contain costs because:

- o individuals recommended for certain elective surgical procedures are required to get an additional opinion on the need for the surgery (this overcomes the low consultation rates that are characteristic of voluntary programs);

- the initiation of a program has a sentinel effect that deters physicians from recommending inappropriate surgery in the first place; and

- a small but still appreciable segment of those receiving second opinions will decide, because of the additional consultation, not to have surgery.

Arguments against the adoption of a mandatory program emphasize the difficulties of administering such a program for the Medicare population to achieve any worthwhile level of savings. Problems might be expected in a number of areas such as:

- the adequacy of beneficiary education, a key feature of employee based programs. Adoption of an SSO program would exacerbate problems created by the already formidable complexity of the Medicare program and the inadequate resources for assisting beneficiaries. Requiring physicians to see that their patients get second opinions is a possibility but would be controversial and could undermine such other objectives as achieving high assignment rates.

- the volume of waived SSO requirements. Insurers with substantial rural and small town subscribers may waive the necessity of second opinions half the time or more because no independent physician consultants are available within reasonable travel distance of the subscriber's home or workplace. Waivers for individuals with limited mobility are another issue. Medicare could probably expect a higher waiver rate than that found in the typical private program.

- high confirmation rates, particularly after the early stages of the program. Given the large numbers of Medicare beneficiaries in an area, creating a selective and rigorous panel of consultants could be difficult and controversial.

In 1986, the Combined Omnibus Reconciliation Act provided for a very selective use of second opinions. Peer Review Organizations are now required to precertify the appropriateness of selected surgical procedures. For cases in which a straightforward judgment by reviewers is not possible, the beneficiary will be expected to get a second opinion. This requirement may be sometimes be waived, for example, when no qualified consultant who accepts assignment is available. HCFA will be monitoring the implementation and results of this new benefits management initiative. Because questions have been raised about the appropriateness of the procedures selected by HCFA for precertification, the Commission will review the list and make recommendations as appropriate.

PER CASE PAYMENT OF RADIOLOGISTS, ANESTHESIOLOGISTS, AND PATHOLOGISTS

A number of alternatives to fee for service have been considered for paying for physicians' services. Medicare pays hospitals on a per case basis, using diagnosis related groups to classify patients. Similar methods have been considered for paying for all physicians' services to hospitalized patients (Congressional Budget Office, 1986; Jencks and Dobson, 1985; Office of Technology Assessment, 1986). A study mandated by Congress that is to assess the feasibility and advisability of such an approach has been under way for some time at the Health Care Financing Administration. The effects of such a change on program costs, efficiency, access, and quality of care are not known.

It has also been suggested that only a subset of physician services to hospitalized patients be paid on the basis of diagnosis related groups: services provided by radiologists, anesthesiologists, and pathologists. This approach received attention in the Congress last year. In response to Congressional interest, the Congressional Research Service and the General Accounting Office initiated studies relating to payment of hospital based physicians. In addition, the Omnibus Budget Reconciliation Act of 1986 mandated a study by the Secretary of HHS.

The Reagan administration recently proposed in its 1988 budget that radiologists, anesthesiologists, and pathologists (RAPs) be paid according to a schedule based on diagnosis related groups. The nature of the administration's proposal--which services the payment is to cover, to whom the payment is to be made, how the payment is to be determined, assignment policy, and so forth--is not yet known.

The Commission intends to examine the merits of paying for this set of physicians' services on a per admission basis. The administration will be asked to present its proposal. The Commission will ask for the results of each of the studies mentioned above, will invite comment from interested groups, and may conduct additional analyses.

CAPITATION

Medicare payment for physicians' services and other medical services through capitation arrangements currently offers an alternative to the fee-for-service system for a relatively small segment of Medicare beneficiaries. With the growth in number and types of private health plans offering services on a capitation basis and increases in enrollments in capitated plans among the general population, the number of Medicare beneficiaries enrolled in such plans also can be expected to grow.

The Tax Equity and Fiscal Responsiblity Reform Act of 1982 authorized Medicare to pay risk-sharing plans on a prospective capitation basis (with the capitation payment based on the costs to Medicare incurred on behalf of comparable beneficiaries who remain in the fee-for-service system), thus ending a decade of Medicare cost-based reimbursement contracts with qualified Health Maintenance Organizations (HMOs). Regulations implementing the act, effective February 1, 1985, described its broadened definition of plans eligible for Medicare capitation payment which included both federally qualified HMOs and Competitive Medical Plans (CMPs). In all cases, Medicare pays the HMO or CMP directly, with the HMO or CMP then contracting with medical groups, individual physicians, and other providers through a variety of financial arrangements, including fee for service.

A capitation payment system can be limited to or encompass more than coverage for physician services. In either case, however, when capitation is applied to physicians' services, it implies delegating to a private entity the responsiblitiy for determining how to pay physicians. The Commission could address both short-term issues related to the current system of capitation payments under Medicare and longer-term issues about the extent to which capitation should be used as a method for physician payment in the Medicare program.

Issues related to Medicare capitation payment fall into a number of areas including:

- improvements in or alternatives to the adjusted average per capita cost method of determining payments to health plans with risk contracts to account for the differences in costs of providing care to different types of enrollees;

- the appropriateness of current limitations on profit rates and on premiums for basic Medicare services and of ceilings on enrollments of Medicare beneficiaries;

- minimum benefit requirements and the prohibition of cash rebates;

- the role of Medicare in monitoring marketing and enrollment activities of health plans and providing consumer information about options available for beneficiaries;

- improvements in quality assurance systems to minimize potential underutilization of medically necessary services and inappropriate barriers to access;

- implications of the degree of financial risk, how it is assumed, and who bears the risk under alternative capitation arrangements; and

- the financial viability of various types of entities providing services through capitation arrangements to Medicare enrollees.

The Commission considers voucher proposals as options to delegate the provision of insurance to private entities, not physician payment options. Vouchers would broaden the definition of a qualified plan to include traditional private insurance with unlimited choice of provider. Likewise, geographic capitation to a carrier or intermediary willing to assume risk for services to all Medicare beneficiaries in a geographic area also reflects a delegation of the insurance function rather than a physician payment option. In the Commission's view, the definition of capitation does not encompass these concepts.

The incentives contained in capitation payment schemes to control medical expenditures can encourage provision of a more efficient mix of services, reduction of inappropriate care, and emphasis on health promotion and early intervention. At the same time, access and protection from excessive out-of-pocket expenses for beneficiaries also can be ensured. The pressure to contain costs can alternatively result in reduction or delay in appropriate services and create barriers to access to care. In addition, biased selection of enrollees, an issue that is less well understood, can result in both excess costs to Medicare and lack of access for beneficiaries. The potential for such adverse effects, which run counter to the Commission's underlying policy principles, will be evaluated in any analysis of Medicare captiation payment issues and options.

APPENDIX

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (P.L. 99-272)

SEC. 9305. PHYSICIAN PAYMENT REVIEW COMMISSION AND DEVELOPMENT OF RELATIVE VALUE SCALE.

(a) ESTABLISHMENT OF COMMISSION - Part B of Title XVIII of the Social Security Act is amended by adding at the end the following new section:

"PHYSICIAN PAYMENT REVIEW COMMISSION

"SEC. 1845 (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of physicians' services appointed by the Director (without regard to the provisions of Title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals.[1] Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

"(3) The membership of the Commission shall include physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly. The Director shall seek nominations from a wide range of groups, including:

"(A) national organizations representing physicians, including medical specialty organizations,

"(B) organizations representing the elderly and consumers,

"(C) national organizations representing medical schools,

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[1]Two new members were appointed to respond to The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) which increased the number of Commission members from 11 to 13.

"(D) national organizations representing hospitals, including teaching hospitals, and

"(E) national organizations representing health benefits programs.

"(b)(1) The Commission shall make recommendations to the Congress, not later than March 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under Section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

"(2) In making its recommendations, the Commission shall:

"(A) consider, and make recommendations on the feasibility and desirability of reducing the differences in payment amounts for physicians' services under this part which are based on differences in geographic location or specialty;

"(B) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

"(C) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of subparagraphs (A) and (B);

"(D) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

"(E) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

"(F) make recommendations respecting the advisability and feasiblity of making changes in the payment system for physicians' services under this part based on (i) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related groups) and (ii) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under this part);

"(G) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval; and

"(H) identify those procedures for which an opinion of a second physician should be required before payment is made under this title.

"(3) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under subsection (e).

"(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

"(A) Subparagraph (C) (relating to staffing and administration generally).

"(B) Subparagraph (D) (relating to compensation of members).

"(C) Subparagraph (F) (relating to access to information).

"(D) Subparagraph (G) (relating to reports and use of funds).

"(E) Subparagraph (H) (relating to periodic GAO audits).

"(F) Subparagraph (J) (relating to requests for appropriations).

"(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall:

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section.

"(B) carry out, or award grants or contracts for original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and

"(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund."

(b) DEVELOPMENT OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES. - Section 1845 of the Social Security Act, as added by subsection (a), is further amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part or under State plans approved under Title XIX.

"(2) In developing the scale, the Secretary shall consider among other items:

"(A) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984.

"(B) the recommendations of the Physician Payment Review Commission under subsection (b)(3), and

"(C) factors with respect to the input costs for furnishing particular physicians' services, such as:

"(i) the differences in costs of furnishing services in different settings.

"(ii) the differences in skill levels and training required to perform the services, and

"(iii) the time required, and risk involved, in furnishing different services.

"(3) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than July 1, 1987. The report shall include recommendations for the application of the scale to payment for physicians' services furnished under this part on or after January 1, 1988."

Reasonable Charge Limits Inherent Reasonableness

Section 4526 - Under the inherent reasonableness authority, the Secretary would be authorized to establish a payment level for a physician service based on considerations other than the actual, customary, or prevailing charge for the service. A departure from the standard methodology would be appropriate under a number of circumstances, including the following: (i) the prevailing charge for a service in a particular locality is significantly in excess of, or below, the prevailing charge for the same service in other comparable localities taking into account the relative costs of furnishing the service; (ii) medicare and medicaid are the sole or primary sources of payment for the service; (iii) the marketplace for the service is not truly competitive; (iv) there have been increases in charges for a service that cannot be explained by inflation or technology; (v) the charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs; (vi) the prevailing charge for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

The Secretary would be authorized to make an adjustment in payment if such adjustment is justified on the basis of an appropriate comparison of resource costs or charges. An adjustment may be based on one of the following types of comparison: (i) a comparison between charges and resource costs for the procedures; (ii) a comparison between charges and resource costs for the procedure over a period of time: (iii) a comparison between charges for a procedure in different geographic areas; and (iv) a comparison betwen charges and allowed payments for a procedure under this part and by other payers. The term "resource costs" includes factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

Adjustments based on comparisons of charges for a procedure in different geographic areas may be made only if the Secretary determines that the prevailing charge allowed in a locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs. The Secretary would not be authorized to establish a uniform fee or payment limit under this provision unless the Secretary determines that there is substantial economic justification for a uniform fee or a uniform payment limit. Such justification would have to be explained in a proposed and final notice.

In determining whether to adjust payments rates, the Secretary would be required to consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.

The Secretary would be required to consult with representatives of physicians likely to be affected at an appropriate stage in the process. The Secretary would also be required to publish a proposed notice: (i) specifying the charge or methodology proposed to be established, (ii) explaining the factors and data on which the proposal is based, and (iii) explaining the potential impacts on quality, access, and beneficiary liability. After publication of the proposed notice, the Secretary would be required to allow 60 days for public comment. The Physician Payment Review Commission would be required to comment on the proposal, and the Secretary would be required to take into account the comments made by the Commission and by the public in making a final determination. The final notice shall explain the factors and data that the Secretary took into consideration in making a final determination and must include and respond to the comments made by the Commission.

If an adjustment is made that results in a reduction in the payments allowed for a service, a special limit on actual charges for nonparticipating physicians would apply. The purpose of this special limit is to moderate beneficiary liability for charges in excess of the medicare approved charge. For the first year the reduction is in effect, the maximum allowable actual charge for the service equals 125% of the inherently reasonable charge level plus one-half of the difference between the physician's actual charge in the preceding period and 125% of the inherently reasonable charge level. In the second year, the special maximum allowable charge for the service equals 125% of the inherently reasonable charge level.

The Secretary is required to review payments under this section for 10 of the most costly procedures paid for under Part B. The Secretary should have flexibility in choosing the procedures in terms of those for which modifications might be the most cost effective. If the Secretary determines that for one or more of such overpriced procedures that a payment adjustment cannot be made pursuant to this section, he shall report recommendations to Congress concerning appropriate statutory changes.

Technical Amendments and Miscellaneous Provisions Relating to Part B

Section 10234 - Expands the membership of the Physician Payment Review Commission by 2 members to 13. The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Commission no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the

Director may provide initially for such terms as will ensure that (on a continuing basis) the terms of no more than five members expire in any 1 year.

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